



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING



NICK LYON  
DIRECTOR

July 20, 2016

Julie Avant  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

Dear Ms. Avant:

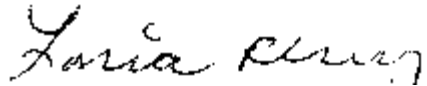
Attached is the Interim Inspection Report for the above referenced facility completed on June 29, 2016 thru June 30, 2016; and July 5, 2016 thru July 6, 2016. Due to the violations of applicable licensing rules, sections of the contract and Implementation Sustainability and Exit Plan (ISEP), a written corrective action plan is required. It should be noted that violations of any licensing rules are also violations of the ISEP and your contract. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each citation will be achieved.
- An explanation why previous corrective action plans have not obtained and maintained compliance for rules found in repeat non-compliance.
- Who is directly responsible for implementing the corrective action for each licensing statute and rule or section of the contract or MSA citation.
- Specific time frames for each citation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

Upon receipt of an acceptable corrective action plan, a six-month second provisional license will be issued. If you do not agree to a second provisional license or fail to submit an acceptable corrective action plan, disciplinary action will result.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the area manager at (248) 975-5053.

Sincerely,

A handwritten signature in cursive script that reads "Lonia Perry".

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
RENEWAL INSPECTION REPORT**

**I. IDENTIFYING INFORMATION**

**License #:** CI820297847

**Licensee Name:** Detroit Behavioral Institute

**Licensee Address:** Suite A  
1333 Brewery Prk Blvd#140  
Detroit, MI 48207

**Licensee Telephone #:** 313-576-5009

**Administrator/Licensee Designee:** Julie Avant, Designee

**Name of Facility:** Detroit Capstone

**Facility Address:** 3500 John R St.  
Detroit, MI 48201

**Facility Telephone #:** (313) 576-5009

**Original Issuance Date:** 12/23/2008

**CMH Funded Facility** NO

<u>Program</u> <u>Type</u>	<u>Setting</u>	<u>Gender</u>	<u>Capacity</u>	<u>From</u> <u>Age</u>	<u>Thru</u> <u>Age</u>	<u>Behavior</u> <u>Mgt.</u> <u>Room</u>	<u>Location</u>
Treatment	Secure	BOTH	74	10	17	YES	John R.

## II. METHODS OF INSPECTION

Date of On-site Inspection 6/29/2016 thru 06/30/2016; 07/05/2016 thru 07/06/2016

Date of Fire Inspection: 08/21/2014

Date of Environmental/Health Inspection: 10/17/2014

	Total No. of Records	No. of Records Reviewed	
No. of current residents ( <b><i>secure-treatment</i></b> )	73	8	
No. of current residents ( <b><i>secure-shortterm</i></b> )	NA		
No. of current residents ( <b><i>open-treatment</i></b> )	NA		
No. of current residents ( <b><i>open-shortterm</i></b> )	NA		
No. who have left the program since the last inspection ( <b><i>secure-treatment</i></b> )	68	8	
No. who have left the program since the last inspection ( <b><i>secure-shortterm</i></b> )	NA		
No. who have left the program since the last inspection ( <b><i>open-treatment</i></b> )	NA		
No. who have left the program since the last inspection ( <b><i>open-shortterm</i></b> )	NA		
No. of Facility Restraints since the last inspection	991	40	
No. of Facility Seclusions since the last inspection	7	7	
No. of current employees who have worked at the facility for:		No. of Records Reviewed	
More than a year	71	9	
Less than a year	42	42	
No. Of persons Interviewed:			
Direct Care Staff	5		
Supervisory Staff	1		
Administrators	1		
Residents	7		

The following required records were on file and available for review:

Program Statement	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Program Policies	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Staff Training Records	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Income/Expenditure for current year, including most recent Financial audit	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Staff TB Screening Records	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Staff to Resident Ratio	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Posted Notice: Criminal History Check for employees and volunteers	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA
Criminal History and Child Protection Registry Checks for employees and volunteers	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Volunteer Supervision Policy	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Behavior Management Room Log	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Meal Menus	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA

### III. DESCRIPTION OF FINDINGS

- 1.) The facility is in compliance with all applicable rules and statutes except for the following:

**MCL 722.113e      Criminal history check required; posting notice; rules.**

The operator of a child care center or child caring institution shall conspicuously post on the premises a notice stating whether or not that child care center or child caring institution requires a criminal history check on its employees or volunteers. The department shall promulgate rules to implement this section under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

The posting as required by the statute was not on the premises.

**R 400.4109      Program statement.**

(1) An institution shall have and follow a current written program statement which specially addresses all of the following:

(c) Policies and procedures pertaining to admission, care, safety, and supervision, methods for addressing resident's needs, implementation of treatment plans, and discharge of residents.

The facility policy requires a 90 day performance evaluation for new employees.

Five of forty-one new employee records reviewed showed the employee's 90 day evaluation was completed late:

- Two were seventeen days late, per its 5/15/16 due date in respect to the employee's 2/15/16 date of hire, and the employee's and supervisor's 6/1/16 dated signature on the evaluation.
- A third was twenty-three days late, per its 3/1/16 due date, in respect to the employee's 12/1/15 date of hire, and the employee's and supervisor's 3/24/16 dated signature on the evaluation.
- A fourth was thirty-five days late, per its 3/1/16 due date, in respect to the employee's 12/1/15 date of hire, and the employee's and supervisor's 4/4/16 dated signature on the evaluation.

- A fifth was thirty-seven days late, per its 5/15/16 due date, in respect to the employee's 2/15/16 date of hire, and the employee's and supervisor's 6/21/16 dated signature on the evaluation.

## **R 400.4113**

### **Employee records.**

An institution shall maintain employee records for each employee and shall include documentation of all of the following information prior to employment or at the time specified in this rule:

(e) Three dated references which are obtained prior to employment from persons unrelated to the employee and which are less than 12 months old.

Ten of forty-one new employee records reviewed did not show documentation of compliance:

- One employee's record showed one of the three references, did not show clear indication of the person's relationship to the employee; it could not be discerned if the reference person was unrelated to the employee.
- A second record showed one of three of the references was not dated, and it could not be discerned if it was received before the employee's 4/25/16 date of hire.
- A third record showed that of the employee's three references, one was received after the employee's 2/15/16 date of hire; and one reference was not dated, making it difficult to discern if it was received prior to the employee's date of hire.
- Six other employee records showed one or more of the employee's three references were received one day or more after the respective employee's 12/1/15, 1/11/16, 2/15/15, 5/9/16, 5/9/16 and 6/6/16 date of hire.

### **Repeat Violation-Interim 2015.**

#### **Consultation:**

In one of forty-one new employee records reviewed, the record showed a letter documented as a reference, which was verification of the applicant's date of employment, and the role the employee had with a prior employer, with a notification that the facility could contact them for additional information. The agency is advised from a best practice standard, follow up in such cases is advisable.

**R 400.4113****Employee records.**

An institution shall maintain employee records for each employee and shall include documentation of all of the following information prior to employment or at the time specified in this rule:

(j) A written evaluation of the employee's performance within 30 days of the completion of the probationary period or within 180 days, whichever is less, and a written evaluation of the employee's performance annually thereafter

In four of fifty-one employee records reviewed where the employee had been employed for over one year, the record did not show documentation of rule compliance:

- Three records did not show documentation of the employee's annual evaluation, due respectively by 10/21/15, 3/24/16, and 6/8/16.
- A fourth record showed documentation of a 3/8/16 evaluation, reportedly for the period 12/12/14-12/12/15 though the prior evaluation on file was dated 1/8/14.

**Repeat Violation- Interim 2015.****R 400.4114****Tuberculosis screening for employees and volunteers.**

The licensee shall document, prior to employment, that each employee and volunteer who has contact with residents 4 or more hours per week for more than 2 consecutive weeks is free from communicable tuberculosis. Freedom from communicable tuberculosis shall be verified within the 1-year period before employment and shall be verified every 1 year after the last verification or prior to the expiration of the current verification.

Five of fifty-one employee records reviewed did not show documentation of compliance:

- One new employee record showed the employee's tuberculosis screening was completed two days after the respective employee's 1/11/16 date of hire.
- A second and third new employee record showed the employee's tuberculosis screening was completed three days after the employee's 5/9/16 date of hire.
- A fourth and fifth new employee record showed the employee's tuberculosis screening was completed seven days after the employee's 4/11/16 date of hire.



**Repeat Violation- Interim 2015.**

**R 400.4146**

**Immunizations.**

(1) A resident shall have current immunizations as required by the department of community health.

Two of eight open resident records reviewed showed documentation that the resident had immunizations that were overdue.

**Repeat Violation-Interim 2015.**

**R400.4147**

**Dental Care**

(2)A dental examination within 12 months prior to admission shall be documented or there shall be an examination not later than 90 calendar days following admission.

Three of eight open resident records reviewed did not show documentation of compliance:

- One record showed the resident's dental exam completed 5/6/16 was thirty-seven days late, per the resident's 12/11/15 date of admission.
- A second and third resident's record, did not show documentation of a dental exam for the respective resident's due by 6/28/16, making it two days late at the time of the file review, per the respective resident's 3/29/16 date of admission.

**Repeat Violation- Interim 2015.**

**R400.4152**

**Initial documentation.**

At the time of admission, all of the following shall be in the resident's case record:

(a)Name, address, birth date, gender, race, height, weight, hair color, eye color, identifying marks, religious preference, and school status.

(c) A brief description of the resident's preparation for placement and general physical and emotional state at the time of admission.

(d) Name, address, and marital status of parents and name and address of legal guardian, if known

(e) Date of admission and legal status.

- (f) Documentation of legal right to provide care.
- (h) A brief description of the circumstances leading to the need for care.
- (i) Documentation that the grievance policy was provided as required in R400.4132.

**(a):**

Two of eight open resident records reviewed did not show documentation as to if the resident had identifying marks, as required by the rule.

**(c):**

Five of eight open resident records reviewed did not show documentation of the resident's preparation for placement.

**(d):**

Two of eight open resident records reviewed did not show documentation of the marital status of the youth's parents.

**(e):**

Two of eight open resident records reviewed did not show documentation of the youth's legal status, at the time of admission.

**(f):**

Two of eight open resident records reviewed did not show documentation of a legal right to provide care; in that a court order, placement order or 3600 was not on file. One of these residents was placed out of the state of Tennessee; and it did not show documentation of the approval from ICPC (Interstate Compact on the Placement of Children).

**(h):**

In three of eight open resident records reviewed, documentation of the circumstances leading to the resident's placement was not clearly or not sufficiently documented.

**(i):**

In one of eight open resident records reviewed, the record showed documentation that the resident was provided the grievance policy 6/28/16, which was after the resident's 5/3/16 date of admission.

**(c), (e), (f), (h), and (i) Are Repeat Violations- Interim 2015.**

**R 400.4155**

**Institutions not detention institutions or shelter care institutions; initial treatment plan.**

(3) The initial treatment plan shall include all of the following:

- (a) An assessment of the residents and family's strengths and needs.
- (b) Plans for parent and child visitation.
- (c) Treatment goals to remedy the problems of the resident and family, and time frames for achieving the goals.
- (g) Projected length of stay and next placement.

**(a):**

In two of eight open resident records reviewed, the initial treatment plan did not show documentation of an assessment of the resident's family's strengths and needs.

**(b):**

In five of eight open resident records reviewed, the initial treatment plan did not show documentation of the plan for parent and child visitation.

**(c):**

In one of eight open resident records reviewed, the initial treatment plan did not show clear documentation of treatment goals to remedy the problems of the resident and family and time frames for achieving the goals.

**(g):**

In four of eight open resident records reviewed, the initial treatment plan did not show documentation of the projected length of stay.

**Repeat Violation- Interim 2015.**

**Technical assistance R400.4155 (5).**

The agency was apprised the initial treatment plan shall consistently show documentation of the date the supervisor signed it.

**R400.4156**

**Institutions not detention institutions or shelter care institutions; updated treatment plan**

(3) The updated treatment plan shall include all of the following information:

- (a) Dates, persons contacted, type of contact, and place of contact.

(b) Progress made toward achieving the goals established in the previous treatment plan.

**(a):**

Two of eight open resident records reviewed did not show the documentation as required by this rule.

**(b):**

In one of eight open resident records reviewed the progress for the prior goals were not clearly described.

**(a) Is a Repeat Violation- Interim 2015.**

**R400.4166**

**Discharge plan.**

(1)When a resident is discharged from the institutional care, all of the following information shall be documented in the case record within 14 day after discharge:

(c) An assessment of the resident's needs that remain to be met.

(d) Any services that will be provided by the facility after discharge.

(f) The name and the official title of the person to whom the resident was discharged.

**(c):**

Two of eight closed resident records reviewed did not show clear documentation of the resident's needs that remain to be met.

**(d):**

Five of eight closed resident records reviewed did not show documentation as to if any services will be provided by the facility after discharge.

**Consultation**

If no services are to be provided after discharge, the facility is advised documenting no services needed would meet the rule requirements.

**(f):**

The agency uses both a discharge plan and a Medical discharge plan, on which, both have a line for who the resident was released to. In three of eight closed resident records reviewed the record did not show clear documentation of the person, the youth was released to. Documentation either did not match and or was not legible.

**(d), (f) Are Repeat Violations-Interim 2015.**

**Technical assistance R400.4166(1)(a):**

The new location shall include the address of the new location.

**R400.4167**

**Case record maintenance.**

(2) Service plans shall be signed and dated by the social services workers and the social services supervisors.

In one of eight closed resident records reviewed, the youth's discharge release plan was not signed by the worker, supervisor, parent or youth.

**R400.4407**

**Facility and premises maintenance.**

(1) A facility and premises shall be maintained in a clean, comfortable, and safe condition. The facility shall be located on land that is properly drained.

A tour of the facility showed:

- The kitchen sinks were stained, in need of deep cleaning; and an overhead shelf was dirty/embedded with something, and in need of scrub cleaning.
- One of the residents' showers had a heating vent, (which is reportedly not in use, the vents were sealed), that was covered with rust.
- One of the boys' and girls' showers had tiles that appeared not clean, was stained and in need of deep cleaning.
- One of the boys' shower rooms had a broken shower rod. The rod was repaired after this consultant commented on it during the tour.

It is noteworthy that the Environmental Quality Director, Mr. Williams, indicated, the facility has attempted to clean the shower walls and floor shower tiles, but what they did was not effective, and that deep cleanings via a company is to begin 7/6/16; and will be done every six months. Mr. Williams provided a copy of a proposal from A Klein Company Commercial Cleaning Services for such, dated 6/13/16; and an email correspondence to and from the company related to accessing the premises 7/6/16, and 7/7/16.

Mr. Williams also indicated new breakaway shower curtains that hold in place via a specific track will be installed in two weeks. It's believed this should eliminate the problem that exists now

with the plastic rods (which are held in place with black electrical looking tape) breaking. A copy of a proposal for such shower curtains, from Imperial Fastener Company, dated 7/1/16, was provided to this consultant.

**Corrected on-site- No further Corrective Action Plan required related to the showers and tiles/cleaning and shower curtain only.**

#### **Repeat Violation-Interim 2015**

**R400.4407**

#### **Facility and premises maintenance.**

(5) Floors, interior walls, and ceilings shall be sound and in good repair and shall be maintained in a clean condition

Per tour of the facility, the following was observed:

- One of its group rooms had a hole in the wall, near the molding; and one could easily stick a hand or foot in the hole. **Corrected on-site, No further Corrective Action Plan required related to this specific issue.**
- Two residents' rooms were observed to have a large spot where paint had come off or been pulled from the wall.
- One female resident's room had a sink which did not work properly.

#### **Repeat Violation, included in citation under (1)-Interim 2015.**

It is noteworthy the facility's Environmental Quality Director, indicated that painting of the residents' rooms would occur on an ongoing basis.

2.) Any violation listed in section 1 is also an ISEP violation. Please note that there are additional ISEP requirements that may not be included in section 1. The facility is in compliance with all additional ISEP requirements except for the following: No other.

3.) Any violation listed in section 1 is also a DHHS Contract/Policy violation. Please note that there are additional DHHS Contract/Policy requirements that may not be included in section 1. The facility is in compliance with all additional DHHS Contract/Policy requirements except for the following:

**Contract/Policy-  
FOM 802-1**

**Psychotropic Medication In Foster Care.**

**Informed Consent :**

The supervising agency must obtain informed consent for each psychotropic medication prescribed to a child in foster care. An informed consent is consent for treatment, provided after an explanation from the prescribing clinician to the consenting party of the proposed treatment, expected outcomes, side effects, and risks. The DHS-1643, Psychotropic Medication Informed Consent, must be used to document this discussion between the prescribing clinician and the consenting party. The DHS-1643, Psychotropic Medication Informed Consent, is a mandatory form that must be completed as directed on the form.

**Authority to Consent**

Consent is required for the prescription and use of all psychotropic medications, including those prescribed for continued use in a hospital setting, upon discharge from a hospital, or as a result of outpatient treatment, for all foster children. The DHS-1643, Psychotropic Medication Informed Consent, must be used to authorize consent.

Five of eight open resident records reviewed did not show documentation of the DHS-1643 consent for the resident's prescribed psychotropic medication, as required by the standard.

**Repeat Violation-Interim 2015.**

**Contract-RFJJ-**

**J- Service to be provided**

**b. Standardized Assessment Tools**

The contractor shall utilize the following assessment tools to assess the child's overall progress in functions while in the residential program:

2. Michigan Juvenile Justice Assessment System (MJJAS).
3. Ansell Casey Life Skills or Daniel Memorial Assessment (for children 14 year of age and older).

The Contractor may utilize additional standardized and reliable assessment tools to assess overall progress in functioning. Additional program specific assessment tools required by MDHHS are identified within each Service Description in Attachment A.

The Contractor shall administer the required assessment tools until the youth is released and document the scores in MiSACWIS.

Five of eight open resident records reviewed did not show compliance:

- One record showed documentation of a Casey assessment, but not the MJJAS, and it could not be ascertained when that assessment was completed or by whom.
- Four other records did not show documentation of the MJJAS as required, or the Casey or Daniel Memorial assessment for three of these residents who required the assessment.

### **3 Is a Repeat Violation- Interim 2015.**

#### **Contract-RFCJJ J- Service to be Provided.**

##### **d. Criminogenic Rehabilitation Services and Specialized Treatment**

1) Youth shall be assessed using the MJJAS. The results of the assessments shall be utilized to formulate individualized treatment plans in MiSACWIS. The MJJAS Residential Tool must be completed with the Initial Treatment Plan. The MJJAS Reentry Tool must be completed with every other Updated Treatment Plan.

Five of eight open resident records reviewed did not show documentation as required by the standard.

#### **Contract-RFJJ- Independent Living Preparation**

##### **2. 10. q**

Independent living preparation is defined as a comprehensive and coordinated set of activities that will assist all youth in preparing for a state of independence or providing care of oneself socially, economically, and psychologically. Independent living preparation activities shall be focused on the results of the Casey Life Skills Assessment that indicate an area of need, when the youth is age 14 or older. The Contractor shall identify independent living activities in the youth's treatment plan.

Four of eight open resident records reviewed did not show documentation of independent living preparation based on the



Casey Life Skills Assessment.

**Contract- RFCJJ J Service to be Provided.**  
**8. Transitional Service With the Youth After She/he Leaves Placement.**

a. In a Planned Release, the Contract shall:  
(i) Complete and distribute the Release Plan to the JJS/Child Case Worker, the court and the family prior to the Release Hearing.

One of eight closed resident records reviewed did not show clear documentation that the Release Plan was provided to the parent prior to the youth's release hearing. The Release Plan was not signed by the therapist, supervisor, youth, or parent related to the youth's 10/23/15 discharged.

**Contract-RFCJJ- J Service to be Provided.**  
**23. Prison Rape Elimination Act**

The contractor shall comply with all provisions of the Prison Rape Elimination Act (PREA). Compliance with PREA will be monitored by BCAL. Action should be taken and documented that:

(c) Ensure youth knowledge of PREA regulations.

One of eight open resident records reviewed showed documentation that youth was provided knowledge of PREA on 6/28/16, after her 5/3/16 date of admission.

#### **IV. TECHNICAL ASSISTANCE**

The facility was offered technical assistance in the following areas:

- Contract MiSACWIS data and documentation entry and uploads.
  - The agency was apprised it shall use MiSACWIS as required to demonstrate compliance with the standard.
- Technical assistance as indicated within this report.

#### **V. CONSULTATION**

The facility was offered consultation in the following areas:

- Consultation as indicated within this report.

## EVALUATION OF RENEWAL PERIOD

**There was two incident of substantiated child abuse and/or neglect during this licensing period.**

**Special investigation 2016C0420006**, initiated November 17, 2015, related to an allegation that a resident was assaulted by a staff, and the resident sustained a mark on his face, and scratches to his neck; and a subsequent allegation that the staff pushed another resident, hit that resident in the face with a basketball; and hit yet another resident and swung on a fourth resident. The findings of the investigation substantiated on the initial allegation; but not the subsequent allegations. The facility received a violation under R400.4158 (2) (a) for Discipline. A central registry listing also occurred for that staff involved. The agency submitted an acceptable corrective action plan, which indicated the staff involved was terminated; and that to improve staff skills in responding to residents' behaviors, additional training would be provided to all staff in regards to the behavior management system.

The facility's corrective action plan was unsuccessful in general, in that it received another substantiated abuse/neglect finding related to another staff, a few months after the report was submitted on the above case. That special investigation is indicated below.

**Special investigation 2016C0420024**, was initiated March 2, 2016 related to an allegation that a staff bit a resident's finger and choked the resident during physical management. The investigative findings resulted in the substantiation of the allegation; related to the youth's finger; and the facility received violations under R400.4112 (1) (a) for Staff qualifications; and R400.4158 (2) (a) for Discipline. The facility also received a citation for R400.4109 (1) (c) for Program statement, in that the staff did not follow proper protocol when she engaged and restrained the resident. A central registry listing also occurred for the staff involved. The agency submitted an acceptable corrective action plan on May 13, 2016, that indicated the staff in question was terminated on April 12, 2016; and six new staff had been identified to complete training; and updated training to other staff.

The facility's corrective action plan was submitted timely and repeat violations in this area have not occurred.

**There were one incident of substantiated corporal punishment during this licensing period.**

**Special investigation 2016C0217016**, initiated January 26, 2016, pertained to an allegation that a staff improperly restrained a resident causing bruises on the resident's back. The investigation resulted in the facility being found in violation of R400.4155 (1) for Behavior management, as the evidence showed the staff involved pulled the resident by the arms to move him from the shower door; carried the resident by the

waist from one end of the hallway to the group room; and did not follow Handle with Care restraint techniques in the physical management of the resident.

The facility was also found in violation of R400.4127 (1) for Staff to resident ratio, in that the staff involved was supervising five residents, when the staff- to-resident ratio was one to four. An additional violation was found for R400.4127 (4) for Staff to resident ratio, in that a resident was in her room on sick call and a staff failed to check on the resident within the fifteen minutes interval. The facility submitted an acceptable corrective action plan on March 11, 2016, that indicated the staff involved received disciplinary actions related to the incident; and would complete retraining of Handle with Care by March 31, 2016; that staff would be notified and receive additional instructions addressing the importance of staying in ratio at all times; that concerns regarding the ability to maintain ratio (including needs for bathroom breaks) must be addressed by the staff with the supervisor; that staff would be notified and receive additional instructions addressing the importance of completing room checks for all youths on sick calls, and that interval checks should not exceed fifteen minutes.

The agency was not totally successful with all aspects of this corrective action plan in that it received a repeat violation for R400.4127 (1) for Staff to resident ratio in connection to special investigation 2016C0420015.

**The facility has submitted ten acceptable corrective action plans not related to maltreatment during this licensing period.**

**Special investigation 2015C042050**, reported in the 2015 Interim report as completed; and that the corrective action plan was pending pertaining to an investigative violation of R400.4109(c) for Program statement, with respect to the supervisor in question job description, role, and his demeanor when he approached a resident to restrain him.

The facility submitted an acceptable corrective action plan on December 3, 2015, that indicated, the supervisor involved was placed on leave of absence during the investigation; and thereafter he received written counseling, retraining on Handle with Care de-escalation techniques; and oversight and supervision.

The facility was successful with this corrective action plan; no additionally complaints have been received related to this staff.

**Special investigation 2015C042051**, reported in the 2015 Interim report as completed; and that the corrective action plan was pending pertaining to investigative violations of R400.4127 (3) for Staff to resident ratio; and R400.4109 for Program statement, related to an incident of three residents AWOLing from the secure facility; and the windows not being secured effectively. The facility submitted an acceptable corrective action plan on November 10, 2015 that indicated night time monitoring procedures were developed to address actions expected by staff during the night time rounds; night time room monitoring review; and training was to be completed for all staff involved in night time room checks on the updated process. Additionally, the corrective action plan indicated the windows were repaired by an outside company; all exterior windows stops were re-

secured with longer screws; and that weekly room inspections were being implemented by staff to check for signs of safety/security issues.

The facility was timely with the submission of the corrective action plan; and it appears to have been successful with it, in that there have been no new complaints or substantiations in this area.

**Special investigation 2015C0420055**, initiated September 10, 2015, pertained to allegations that a resident was being hurt and physically mistreated by staff. The investigation findings did not result in rule violations related to the allegation; yet an additional findings violation was substantiated for R400.4127 (4) for Staff to resident ratio; and R400.4150 (1) for Incident reporting, in that the facility failed to provide monitoring logs showing documentation of the reported room checks; and failed to report a youth's attempted self-harming incident, which resulted in the youth's hospitalization and subsequent admittance to a psychiatric facility. The facility submitted an acceptable correction action plan on February 11, 2016 that indicated room monitoring log bins were being added on each unit to collect the monitoring logs; supervisors would receive additional training on the monitoring log process; a form specific to sick calls was created to document implementation and rationale for sick calls by staff; and that the reporting procedure had been updated to ensure that the shift supervisor submits such incident reports to the licensing consultant within 24 hours.

The facility was not successful with this correction action plan, in that it received a repeat violation for R400.4127(4) for Staff to resident ratio in connection to special investigation 2016C0217016; and R400.4150(1) for Incident reporting, in connection to special investigation 2016C0420014, 2016C0420015 and 2016C0420010.

**Special investigation 2016C0217015**, initiated January 26, 2016, was related to an allegation that the facility placed residents on lockdown without programming. The investigative findings resulted in violation of R400.4109 (1) (a) (b) (c) and (2), as the facility deviated from its daily schedule and regular policy and procedures, when the modified programming was implemented. The facility submitted an acceptable corrective plan on March 9, 2016 that indicated the facility's policy had been updated to standards for program modifications; that a form had been created to document changes pertaining to any program changes that would occur; the reason for the modification; length of time of the modification, and reintegration plan for returning to regular programming. Supervisory staff were to be trained on the new policy/procedure by March 31, 2016.

The facility was timely in submitting this corrective action plan and there have been no evidence to suggest the facility is not in compliance with this corrective action plan.

**Special investigation 2016C0420015**, initiated January 26, 2016, was related to an allegation that a resident was found lying on the floor with a cloth on his neck; his skin was bluish in color; and he was sent to the emergency room. The investigation found the facility in violation of R400.4127 (3) for Staff to resident ratio; and additional

violations for R400.4127 for Staff to resident ratio; R400.4109 (1) (c) for Program statement; and R400.4150 for Incident reporting. The resident, a known self-harmer, who had been on one-to-one staffing supervision prior, had been able to tie an item around his neck to the point of semi-consciousness though he was in the facility's camera monitored close observation room used to monitor youths with self-harming behaviors; the camera in the room was not functioning and the facility had knowledge of the malfunctioning camera, and had not yet repaired the camera; the staff- to- resident ratio was out of capacity for a period of time during the time of the incident; and the reporting of the resident's self-harming and hospitalization was not reported timely to the Division of Child Welfare Licensing(DCWL). On March 14, 2016, the facility submitted an acceptable corrective action plan that indicated the clinical staff would receive training on the one-to-one staff review policy, addressing documentation, justification and approval for removal of a resident from one-to-one staffing; that staff would be notified and receive additional instructions addressing sick call assessments and bedroom monitoring; as well as, would be given instructions on the facility's policy for monitoring checks in this area; and the importance of timely reporting of a serious injury of a resident to DCWL within 24 hours of the incident.

The facility was timely in its submission of the corrective action plan; yet it was either not successful with the corrective action plan and its implementation; or it did not have time to fully operationalize it. A repeat violation to R400.4150 (1) for Incident reporting occurred in special investigation 2016C0420014, and 2016C0420010; as well as, to R400.4109(1)(c) for program statement related to special investigation 2016C0420020 .

**Special investigation 2016C0420014** initiated January 19, 2016, was related to allegations that a resident's face was slammed into the floor of the elevator following a restraint and escort, and that the incident left an abrasion on the resident's cheek. The investigation findings concluded the facility was not in violation of a rule related to the allegation; but the facility was found in violation of R400.4150 (1) for Incident reporting. The investigation revealed the resident, who had attempted to self-harm by allegedly swallowing a battery, was taken to the emergency room; was subsequently admitted to Kingwood hospital; and thereafter was released back to the facility. The resident's hospitalization, and the events leading to it, were not reported to DCWL.

On April 4, 2016, the facility submitted an acceptable corrective action plan that indicated the facility's reporting protocol was immediately updated to clarify and require the lead shift supervisor be responsible for ensuring that all incidents related to the rule are reported to the facility's Risk Manager or designated on-call administrator prior to the end of the shift; and that the Risk Manager or designated on-call administrator would be responsible for notifying DCWL within 24 hours. The corrective action also indicated facility supervisors, managers, nursing staff, and administrative staff would receive additional instructions on the revised protocol.

The agency was timely in its submission of the corrective action plan. At the time of the submission of the corrective action, the report for special investigation 2016C0420010 was submitted with a violation for the same rule.

**Special investigation 2016C0420010**, initiated January 5, 2016, related to allegations that a resident received a gash to his eye during a restraint and was taken to the hospital; the resident received an injury to his chin due to a restraint by staff, and that a staff groped the resident's testicles during a restraint. The investigation did not result in behavior management or staff qualifications violations related to the allegations; but the facility was found in violation of R400.4150(1) for Incident reporting, as the facility had not reported the incident pertaining to the resident's chin injury and emergency room visit to DCWL. On April 12, 2016 the agency submitted an acceptable corrective action plan which outlined the protocol just put in place; and indicated the incident had occurred on the weekend when upper level administrators were not present; there had been a failure in communication between the nursing staff and supervisory staff ensuring that reports of such incidents are reported to DCWL. The corrective action plan included the additional instructions to supervisors, managers, nursing staff, and administrative staff on the revised protocol.

The facility was timely in its submission of the corrective action plan; and thus far, it remains in compliance with this corrective action plan.

**Special investigation 2016C0420020**, initiated February 18, 2016, pertained to staff supervision with respect to two residents engaging in non-consensual sex. The investigation did not find the facility in violation of R400.4127 (3), in that there was insufficient evidence to conclude a lack of direct care and supervision at the time. The facility was found in violation of R400.4109 (1) (c), as the facility did not adhere to its policy that indicated it should consider the youth's physical size and stature, mental illness or mental disabilities, and other specific information when making room assignments; and it not doing so, conceivably may have contributed to the smaller youth's sexual assault by the larger youth.

On May 16, 2016 the agency submitted an acceptable corrective action plan that indicated room assignment and re-assignment procedures had been immediately created to provide clarity on clinical expectations, and staff's roles and responsibilities to the room assignment process; that clinical staff would receive updated training on the procedure and the risk assessment and documentation process; supervisory staff would receive training to the room assignment/reassignment procedure; the perpetrator of the offense was discharged from the facility; a safety plan was put in place for the victim; and the therapist for the resident/victim who placed him in the room with the other resident/perpetrator was no longer employed with the agency.

With respect to this corrective action plan, no information has surfaced to suggest the facility is not in compliance with this corrective action plan.

**Special investigation 2016C0420027**, initiated April 6, 2016, which alleged maltreatment of a past resident; allegation of staff inappropriateness with female residents and offering to assist them after discharge for sexual tasks; inappropriate sexual conduct with a resident; allegations of improper restraints of past residents;



improper food; and the facility being roach infested and dirty. The investigation did not find the facility in violation of rules related to staff qualifications, discipline, resident nutrition, or the facility premises related to rodents and insect harborage. The facility was found in violation of R400.4407 (1) and (5) for premises maintenance; as various areas were observed to not be clean and were in need of sanitizing; various floors, walls, hallways, and showers were dirty and in need of cleaning.

On June 17, 2016, the agency submitted a timely and acceptable corrective action plan that indicated the identified areas had been cleaned, and sanitized; and that cleaning of the door kick plates had been added to maintenance cleaning. The corrective action plan has not been totally successful as repeat violations were identified in this area during this Renewal inspection.

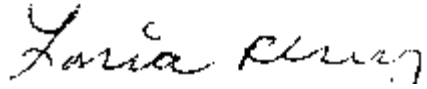
**Special investigation 2016C0420033**, initiated May 6, 2016, related to allegations that a youth was sent to the emergency room after she refused to eat or drink for four to five days and her feet were turning blue (cyanotic); and allegations that the youth's dental needs and MRI was not done timely; and that a staff spoke inappropriately with the youth about her niece. The investigation findings concluded the facility was not in violation of staff to resident ratio pertaining to the youth's attempt at self-harming by not eating or drinking, or supervision of the youth. The facility received a violation for R 400.4142(1) (a) for Health services; policies and procedures in that an MRI was ordered, and x-rays were completed; but the MRI was not completed as ordered by the prescribing doctor. It was also concluded efforts should have been made by facility staff to facilitate the MRI by getting the hospital's questionnaire/document/ consent signed by the child's mother, or getting the case manager involved to facilitate this matter. The facility also received a violation for R400.4147 (2) for Dental care, in that the youth's admission dental was ten days late. The facility's corrective action plan related to this special investigation is pending.

The tenth corrective action plan related to the facility's 2015 Interim inspection where it received a number of violations; and its license was modified from a regular license to a first provisional license. The agency has made some improvements, particularly in the area of employee records and documentation; however there continue to be repeat violations, as documented in this renewal inspection report.

It is noteworthy that three other special investigation reports are pending related to the facility with allegations related to behavioral management, and improper supervision.

**RECOMMENDATION**

Based on inspection findings the facility is not in compliance with all applicable licensing statutes and rules and/or ISEP requirements and/or contract/policy. Upon receipt of an acceptable corrective action plan, it is recommended that the agency be issued a second provisional license.

**July 14, 2016**

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Date

Licensing Consultant





RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING



NICK LYON  
DIRECTOR

January 9, 2017

Derynda Winston  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

Dear Ms. Winston:

Attached is the Renewal Inspection Report for the above referenced facility completed on December 19, 2016 thru December 21, 2016 and December 27, 2016. Due to the violations of applicable licensing rules, sections of the contract and Implementation Sustainability and Exit Plan (ISEP), a written corrective action plan is required. It should be noted that violations of any licensing rules are also violations of the ISEP and your contract. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each citation will be achieved.
- An explanation why previous corrective action plans have not obtained and maintained compliance for rules found in repeat non-compliance.
- Who is directly responsible for implementing the corrective action for each licensing statute and rule or section of the contract or ISEP citation.
- Specific time frames for each citation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the area manager at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
RENEWAL INSPECTION REPORT**

**I. IDENTIFYING INFORMATION**

**License #:** CI820297847

**Licensee Name:** Detroit Behavioral Institute

**Licensee Address:** Suite A  
1333 Brewery Prk Blvd#140  
Detroit, MI 48207

**Licensee Telephone #:** 313-576-5009

**Administrator/Licensee Designee:** Julie Avant, Designee

**Name of Facility:** Detroit Capstone

**Facility Address:** 3500 John R St.  
Detroit, MI 48201

**Facility Telephone #:** (313) 576-5009

**Original Issuance Date:** 12/23/2008

**CMH Funded Facility** NO

<u>Program</u>				<u>From</u>	<u>Thru</u>	<u>Behavior</u>	
<u>Type</u>	<u>Setting</u>	<u>Gender</u>	<u>Capacity</u>	<u>Age</u>	<u>Age</u>	<u>Mgt.</u>	<u>Location</u>
						<u>Room</u>	
Treatment	Secure	BOTH	74	10	17	YES	John R.

## II. METHODS OF INSPECTION

Date of On-site Inspection 12/19/2016 thru 12/21/2016 & 12/27/16

Date of Fire Inspection: 08/19/2016

Date of Environmental/Health Inspection: 04/21/2016

	Total No. of Records	No. of Records Reviewed
No. of current residents ( <b>secure-treatment</b> )	72	8
No. of current residents ( <b>secure-shortterm</b> )	NA	
No. of current residents ( <b>open-treatment</b> )	NA	
No. of current residents ( <b>open-shortterm</b> )	NA	
No. who have left the program since the last inspection ( <b>secure-treatment</b> )	34	6
No. who have left the program since the last inspection ( <b>secure-shortterm</b> )	NA	
No. who have left the program since the last inspection ( <b>open-treatment</b> )	NA	
No. who have left the program since the last inspection ( <b>open-shortterm</b> )	NA	
No. of Facility Restraints since the last inspection	290	39
No. of Facility Seclusions since the last inspection	0	0
No. of current employees who have worked at the facility for:		No. of Records Reviewed
More than a year	85	11
Less than a year	32	32
No. Of persons Interviewed:		
Direct Care Staff	3	
Supervisory Staff	2	
Administrators	2	
Residents	7	

The following required records were on file and available for review:

Program Statement	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Program Policies	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Staff Training Records	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Income/Expenditure for current year, including most recent Financial audit	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Staff TB Screening Records	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Staff to Resident Ratio	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Posted Notice: Criminal History Check for employees and volunteers	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Criminal History and Child Protection Registry Checks for employees and volunteers	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Volunteer Supervision Policy	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Behavior Management Room Log	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Meal Menus	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA

### III. DESCRIPTION OF FINDINGS

- 1.) The facility is in compliance with all applicable rules and statutes except for the following:

#### **R 400.4113**

#### **Employee records.**

An institution shall maintain employee records for each employee and shall include documentation of all of the following information prior to employment or at the time specified in this rule:

(i) Documentation from the Michigan department of human services, the equivalent state or Canadian provincial agency, or equivalent agency in the country where the person usually resides, that the person has not been determined to be a perpetrator of child abuse or child neglect. The documentation shall be completed not more than 30 days prior to the start of employment and every 12 months thereafter.

(j) A written evaluation of the employee's performance within 30 days of the completion of the probationary period or within 180 days, whichever is less, and a written evaluation of the employee's performance annually thereafter

#### **(i):**

Two of forty-three employee records reviewed did not show compliance:

- One record did not show documentation for the annual child abuse/child neglect clearance that was due by 10/21/16.
- A second record showed the annual child abuse/child neglect clearance due by 5/30/16 was completed late, on 10/26/16.

#### **(j):**

Of forty-three employee records reviewed, two records, where the employee had been employed for over one year, showed the employee's annual evaluation was late:

- One was due by 3/9/16 and completed sixteen days late on 3/25/16.
- A second was due by 1/28/16 and completed six months late on 7/28/16.

**(j) Is a Repeat Violation- Renewal July 2016 .**

**R 400.4142**

**Health services; policies and procedures.**

- (a) Routine and emergency medical, and dental, and behavior health care
- (e) Dispensing medication.

In one of eight open resident records reviewed where the youth was placed by way of a CCMO (Central Care Management Organization) on 10/14/16, the record showed the resident was prescribed Abilify and Trazadone medication. A notation of a verbal consent was documented for 10/14/16 and 11/16/16 respectively; but the record did not show documentation of a signed written parental/guardian consent for the medications.

**R400.4147**

**Dental Care**

(2) A dental examination within 12 months prior to admission shall be documented or there shall be an examination not later than 90 calendar days following admission.

Two of eight open resident records reviewed did not show documentation of compliance:

- One record showed the resident's dental exam due by 10/10/16 and completed 11/10/16; this was thirty-one days late per the resident's 7/12/16 date of admission.
- A second record showed the resident's dental exam due by 11/24/16 was not completed making it twenty-seven days late, at the time of the record review.

**Repeat Violation-Renewal July 2016.**

**R400.4152**

**Initial documentation.**

At the time of admission, all of the following shall be in the resident's case record:

- (f) Documentation of legal right to provide care.
- (g) Authorization to provide medical, dental, and surgical care and treatment as provided in section 14a(1),(2), and (3) of 1973 PA 116, MCL 722.14a.
- (i) Documentation that the grievance policy was provided as required in R400.4132.

**(f):**

One of eight open resident records reviewed did not show documentation of legal right to provide care; a 3600 was not on

file.

**(g):**

Two of eight open resident records reviewed did not show compliance:

- One record showed the medical authorization was signed after the resident's 7/12/16 date of admission.
- A second record did not show documentation of a medical authorization to the agency from the parent/guardian.

**(i):**

Three of eight open resident records reviewed did not show compliance:

- One record showed the grievance policy was provided to the resident two days after the resident's 10/14/16 date of admission; and provided to the parent on 11/18/16 per the parent's signature date.
- A second record showed the grievance policy was provided to the resident's parent/guardian on 11/10/16, which was after the resident's 8/26/16 date of admission. The record did not show documentation of when it was provided the referral source.
- A third record showed the grievance policy was provided to the referral source on the 12/14/16 date of admission; but not when it was provided the resident's parent/guardian.

**(f), and (i) Are Repeat Violations- Renewal July 2016.**

**R 400.4155**

**Institutions not detention institutions or shelter care institutions; initial treatment plan.**

(3) The initial treatment plan shall include all of the following:

- (b) Plans for parent and child visitation.
- (g) Projected length of stay and next placement.

**(b):**

In two of eight open resident records reviewed, the initial treatment plan did not show documentation of the plan for parent and child visitation.

**(g):**

In two of eight open resident records reviewed, the initial treatment plan did not show documentation of the projected length of stay.



### **Repeat Violations- Renewal July 2016.**

**R400.4166**

#### **Discharge plan.**

(1) When a resident is discharged from the institutional care, all of the following information shall be documented in the case record within 14 day after discharge:

(c) An assessment of the resident's needs that remain to be met.

**(c):**

Three of eight closed resident records reviewed did not show documentation of the resident's needs that remain to be met; it was left blank on the agency's form.

### **Repeat Violation-Renewal July 2016.**

**R400.4167**

#### **Case record maintenance.**

(2) Service plans shall be signed and dated by the social services workers and the social services supervisors.

Two of eight closed resident records reviewed did not show compliance:

- One record did not show documentation of the resident's December 2015- March 2016; or March 2016- June 2016 updated treatment plan.
- A second record did not show documentation of the resident's 1/11/16-4/11/16 updated treatment plan.

### **Repeat Violation Renewal July 2016.**

**R400.4167**

#### **Case record maintenance.**

(3) Narrative entries in the case record shall be signed and dated by the person making the entry.

Two of eight closed resident records reviewed did not show compliance:

- One record showed narratives on file yet they were not signed or dated.
- A second record did not show narratives on file at the time of the review; and various narratives from 6/27/16-8/21/16 were located, and provided to this consultant. The narratives were not signed or dated.

2.) Any violation listed in section 1 is also an ISEP violation. Please note that there are additional ISEP requirements that may not be included in section 1. The facility is in compliance with all additional ISEP requirements except for the following:

**ISEP 4.22**

**MiSACWIS (Commitment 22).**

DHHS will maintain an operational statewide automated child welfare information system (“**MiSACWIS**”) which will be the primary tracking system and satisfy federal reporting requirements.

Five of eight open resident records reviewed were Department referred residents; and the records did not show required completed documentation that they were being processed and serviced via MiSACWIS. Initial treatment plans, updated treatment plans, assessments, and uploads of various documents (treatment plan signature pages, psychotropic medication consent forms, release plan reports, medicals/dentals, etc.) were not being completed in the system.

Additionally, incident reporting for those residents and at least two other residents did not show consistent incident reporting documentation in MiSACWIS.

It is noteworthy that with regards to completing reports and uploading data in MiSACWIS, the agency reported difficulties due to security issues and or forms being mishandled or lost by authorities that process these documents. The agency also reported experiencing delays in being able to access the system due to misinformation and their staff/therapists not having the proper permissions. They also reported at least one therapist being “kicked off” the system; which they acknowledged discovering was due to that therapist not frequenting the system and therein requiring new security clearance.

It is also noteworthy that the agency experienced some worker/therapist changes; but not all staff changed.

Thus, notwithstanding those noted complications, there have also been Departmental concerns reported related to the agency’s lack of compliance and or deficiencies related to MiSACWIS; and the agency had received a technical assistance warning during its July 2016 Renewal Inspection related to this contractual requirement. Therein, this citation is issued at this time.

3.) Any violation listed in section 1 is also a DHHS Contract/Policy violation. Please note that there are additional DHHS Contract/Policy requirements that may not be included in section 1. The facility is in compliance with all additional DHHS Contract/Policy requirements except for the following:

**Contract/Policy-  
FOM 802-1**

**Psychotropic Medication In Foster Care.**

**Informed Consent :**

The supervising agency must obtain informed consent for each psychotropic medication prescribed to a child in foster care. An informed consent is consent for treatment, provided after an explanation from the prescribing clinician to the consenting party of the proposed treatment, expected outcomes, side effects, and risks. The DHS-1643, Psychotropic Medication Informed Consent, must be used to document this discussion between the prescribing clinician and the consenting party. The DHS-1643, Psychotropic Medication Informed Consent, is a mandatory form that must be completed as directed on the form.

**Authority to Consent**

Consent is required for the prescription and use of all psychotropic medications, including those prescribed for continued use in a hospital setting, upon discharge from a hospital, or as a result of outpatient treatment, for all foster children. The DHS-1643, Psychotropic Medication Informed Consent, must be used to authorize consent.

One of eight open resident records reviewed did not show a timely DHS-1643 consent for the resident's 8/30/16 prescribed psychotropic medication, Trileptol; which the resident began taking 8/31/16. The DHS-1643 was not signed by the parent until 10/1/16 and was not signed by the doctor until 11/11/16.

It is noted the record did show a notation of parental verbal consent for the medication 8/31/16.

**Repeat Violation- Renewal July 2016.**

**Contract-RFJJ-**

**J- Service to be provided**

**b. Standardized Assessment Tools**

The contractor shall utilize the following assessment tools to assess the child's overall progress in functions while in the residential program:

3. Ansell Casey Life Skills or Daniel Memorial Assessment (for children 14 year of age and older).

The Contractor may utilize additional standardized and reliable assessment tools to assess overall progress in functioning. Additional program specific assessment tools required by MDHHS are identified within each Service Description in Attachment A.

The Contractor shall administer the required assessment tools until the youth is released and document the scores in MiSACWIS.

One of eight open resident records reviewed did not show documentation of a Casey assessment.

### **Repeat Violation- Renewal July 2016.**

#### **Technical assistance-2. Michigan Juvenile Justice Assessment System (MJJAS):**

The agency received a citation for this standard during its July 2016 Renewal Inspection, yet due to MJJAS training completion being required before a staff person could complete a MJJAS risk assessment tool, and that required training not being offered by the Department any time prior to December 2016, the agency was not able to complete MJJASs. The agency provided documentation showing all its staff are trained as of December 19, 2016; and the agency was apprised once more by this consultant of its requirements related to this standard; and the agency understands MJJAS risk assessments shall hence forth be completed timely, as required by the standard.

### **Contract RJJ**

#### **Transition Service With The Youth.**

##### **2.10. g.**

(1)The Contractor shall:

(a)Work with the assigned JJS/ Child Case Worker to plan reentry referrals and services consistent with Juvenile Justice Field Services Policy Item JJ4 430, Community Placement & Reentry. This shall include holding monthly Treatment and Transition Team meetings starting six months prior to the youth's planned release date.

(d) The Contractor shall:

(i)Work with the JJS/Child Case Worker to establish a full continuum of services for youth upon release from the Contractor's facility to the community.

(ii) Document the reentry plan and supportive services that have been arranged in the youth's community in the Release Report.  
(iii) Track individual youth for Program Performance Objectives identified in Section 2.11(d-f). below (Expected Program Performance Outcomes), for 6 months following Placement release and document in the MiSACWIS Release Outcomes Reporting.

**(a)**

Two of six closed resident records reviewed were of records where monthly team meetings were required; and the respective record did not show documentation of consistent monthly meetings related to the resident.

**(d):**

One of six closed resident records reviewed did not show clear documentation of (d) as required by the contract standard.

**Contract-RFJJ- Independent Living Preparation**

**2. 10. q**

Independent living preparation is defined as a comprehensive and coordinated set of activities that will assist all youth in preparing for a state of independence or providing care of oneself socially, economically, and psychologically. Independent living preparation activities shall be focused on the results of the Casey Life Skills Assessment that indicate an area of need, when the youth is age 14 or older. The Contractor shall identify independent living activities in the youth's treatment plan.

In three of eight open resident records reviewed the record did not show clear indication the independent living preparation listed in the resident's treatment plan was based on the Casey Life Skills Assessment.

**Repeat Violation- Renewal July 2016.**

**Contract-RFJJ Behavioral Health Services.**

**2.10. r**

A mental health professional shall review and update behavioral health services treatment plans on a monthly basis and document the review in MiSACWIS.

Five of eight open resident records reviewed did not show documentation of such a monthly review.

**Contract- RFCJJ J Service to be Provided.**

**8. Transitional Service With the Youth After She/he Leaves Placement.**

a. In a Planned Release, the Contract shall:

(i) Complete and distribute the Release Plan to the JJS/Child Case Worker, the court and the family prior to the Release Hearing.

One of six closed resident records reviewed did not show documentation that the Release Plan was provided to the parent prior to the youth's release hearing

**Repeat Violation- Renewal July 2016**

**IV. TECHNICAL ASSISTANCE**

The facility was offered technical assistance in the following areas:

**R400.4157 Behavior management (1) and R400.4109 Program Statement (1) (c).**

The agency has a resident restraint acknowledgement form that was documented in various resident records signed by the agency's contractual psychiatrist, which gave the impression the form was a type of blanket consent. Per discussion with the agency, the agency's Quality Assurance/Risk Manager reported the acknowledgement form is to be signed by their medical doctor, not the psychiatrist, as a way to document that their doctor assessed the resident and determined there is no adverse medical reason why the resident cannot be restrained. The agency was apprised to ensure its form is consistently signed by the appropriate doctor.

**Contract RFCJJ 2.10.e.8.b Staff Education and Experience Qualifications.**

- During review of new employee records, it was revealed an intern therapist's job description indicated she was to provide therapeutic and case management services to residents. Per discussion with the agency, the agency indicated this intern does not provide therapeutic services to residents, but she shadows the therapist. The agency indicated and showed further documentation in that identified job description that denotes that intern's role is shadowing of the clinical therapist. The agency acknowledged the inaccuracy and potential concern related to this job description's initial statement and plans to correct it.

**V. CONSULTATION**

The facility was offered consultation in the following areas:

**Contract RFCJJ 2.10 e. 3.a. New Staff Orientation:**

The agency was advised titling its orientation and annual training that covers the Child Protection Law and Mandated Reporting using that stated language; as well as, doing so with respect to other required contractual trainings, may aid it in showing clearer identifying compliance to these contract training requirements. The agency

was also advised that Child Protection Law pamphlets are available via the Department.

### **EVALUATION OF RENEWAL PERIOD**

There were no incidents of substantiated child abuse and/or neglect during this licensing period.

There was one incident of substantiated corporal punishment during this licensing period. That incident related to Special Investigation 2017C042006; and the approved report is pending.

The facility has submitted two acceptable corrective action plans not related to maltreatment during this licensing period.

The first one related to the July 2016 Renewal Inspection where the agency received a number of rule and contract compliance violations; and which resulted in it obtaining a second provisional license. The agency, though not fully successful in completion of all aspects of that corrective action plan, made numerous gains and improvements. In terms of the facility's physical environment, it installed new showers on the boys and girls wings; purchased new bedding for residents, and its general upkeep improved; as did the file documentation. It is also noteworthy that although there were repeat violations indicated in this Renewal Inspection report, there was a decrease in the number records in noncompliance related to those violations.

The second corrective action related to Special Investigation 2016C042049, initiated on September 9, 2016 related, to allegations that the agency gave a resident psychotropic medication without the parent's consent. Based on the evidence, the agency was found in noncompliance of R400.4142 (1) (e) for Health services; policies and procedures; and Departmental policy for Psychotropic Medication in Foster Care, related to Prior to Prescribing; and Informed Consent. The agency also received a citation for R400.4152 (g) for Initial Documentation pertaining to the resident's medical authorization being signed/obtained after the youth's date of admission. The agency submitted an acceptable corrective action plan on November 17, 2016, that indicated training for it nursing staff, updating policy to align with the Department's standard for obtaining written consent; and the nursing staff facilitating communication between the resident's parent/guardian and the contracted psychiatrist.

The facility was not totally successful with this corrective action plan, as it received a repeat violation for each identified rule/standard named above, as so documented in this Renewal Inspection report.

**RECOMMENDATION**

Based on inspection findings the facility is not in compliance with all applicable licensing statutes and rules and/or ISEP requirements and/or contract/policy. Upon receipt of an acceptable corrective action plan, it is recommended that the agency's license status return to that of a regular license.

**January 6, 2017**

---

Date

Licensing Consultant





RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING



NICK LYON  
DIRECTOR

December 27, 2017

Julie Avant  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

Dear Ms. Avant:

Attached is the Renewal Inspection Report for the above referenced facility completed on December 15, 2017 thru December 19, 2017. Due to the violations of applicable licensing rules, sections of the contract and Implementation Sustainability and Exit Plan (ISEP), a written corrective action plan is required. It should be noted that violations of any licensing rules are also violations of the ISEP and your contract. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each citation will be achieved.
- **An explanation why previous corrective action plans have not obtained and maintained compliance for rules found in repeat non-compliance.**
- Who is directly responsible for implementing the corrective action for each licensing statute and rule or section of the contract or ISEP citation.
- Specific time frames for each citation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the area manager at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

CC: Taneisha Henderson, Director

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
RENEWAL INSPECTION REPORT  
AMENDED**

**I. IDENTIFYING INFORMATION**

**License #:** CI820297847

**Licensee Name:** Detroit Behavioral Institute

**Licensee Address:** Suite A  
1333 Brewery Prk Blvd#140  
Detroit, MI 48207

**Licensee Telephone #:** 313-576-5009

**Administrator/Licensee Designee:** Julie Avant, Designee

**Name of Facility:** Detroit Capstone

**Facility Address:** 3500 John R St.  
Detroit, MI 48201

**Facility Telephone #:** (313) 576-5009

**Original Issuance Date:** 12/23/2008

**CMH Funded Facility** NO

<u>Program</u>					<u>From</u>	<u>Thru</u>	<u>Behavior</u>	
<u>Type</u>	<u>Setting</u>	<u>Gender</u>	<u>Capacity</u>		<u>Age</u>	<u>Age</u>	<u>Mgt.</u>	<u>Location</u>
							<u>Room</u>	
Treatment	Secure	BOTH	74		10	17	YES	John R.

## II. METHODS OF INSPECTION

Date of On-site Inspection 12/15/2017 thru 12/19/117

Date of Fire Inspection: 12/15/2017

Date of Environmental/Health Inspection: 12/13/2017

	Total No. of Records	No. of Records Reviewed
No. of current residents ( <b>secure-treatment</b> )	59	4
No. of current residents ( <b>secure-shortterm</b> )	NA	
No. of current residents ( <b>open-treatment</b> )	NA	
No. of current residents ( <b>open-shortterm</b> )	NA	
No. who have left the program since the last inspection ( <b>secure-treatment</b> )	88	3
No. who have left the program since the last inspection ( <b>secure-shortterm</b> )	NA	
No. who have left the program since the last inspection ( <b>open-treatment</b> )	NA	
No. who have left the program since the last inspection ( <b>open-shortterm</b> )	NA	
No. of Facility Restraints since the last inspection Incident Reports)	769	40 (22
No. of Facility Seclusions since the last inspection	0	0
		No. of Records Reviewed
No. of current employees who have worked at the facility for:		
More than a year	82	8
Less than a year	42	42
No. Of persons Interviewed:		
Direct Care Staff	4	
Supervisory Staff	2	
Administrators	2	
Residents	5	

The following required records were on file and available for review:

Program Statement	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Program Policies	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Staff Training Records	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Income/Expenditure for current year, including most recent Financial audit	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Staff TB Screening Records	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Staff to Resident Ratio	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Posted Notice: Criminal History Check for employees and volunteers	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Criminal History and Child Protection Registry Checks for employees and volunteers	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Volunteer Supervision Policy	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Behavior Management Room Log	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Meal Menus	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA

### III. DESCRIPTION OF FINDINGS

- 1.) The facility is in compliance with all applicable rules and statutes except for the following:

#### **R400.4111**

##### **Job description.**

An institution shall provide a job description for each staff position that identifies rules, required qualifications, and lines of authority.

One of forty-two new employee records reviewed for a job description did not delineate lines of authority.

#### **R 400.4113**

##### **Employee records.**

An institution shall maintain employee records for each employee and shall include documentation of all of the following information prior to employment or at the time specified in this rule:

(i) Documentation from the Michigan department of human services, the equivalent state or Canadian provincial agency, or equivalent agency in the country where the person usually resides, that the person has not been determined to be a perpetrator of child abuse or child neglect. The documentation shall be completed not more than 30 days prior to the start of employment and every 12 months thereafter.

One of fifty employee records reviewed showed the employee's annual child abuse/neglect clearance was 37 days late. It was due by 2/6/17 but was not completed until 3/14/17.

##### **Repeat Violation- Renewal December 2016.**

#### **R 400.4114**

##### **Tuberculosis screening for employees and volunteers.**

The licensee shall document, prior to employment, that each employee and volunteer who has contact with residents 4 or more hours per week for more than 2 consecutive weeks is free from communicable tuberculosis. Freedom from communicable tuberculosis shall be verified within the 1-year period before employment and shall be verified every 1 year after the last verification or prior to the expiration of the current verification.

Four of fifty employee records reviewed did not show verification prior to the expiration of the current tuberculosis verification.

Three employee's updated tuberculosis screenings were completed late. An employee tuberculosis screening due 12/8/17 was completed eight days late. A second employee tuberculosis screening due 12/1/17 was ten days late. A third employee tuberculosis screening due 8/3/17 was seventy-five days late.

A fourth employee's updated tuberculosis screening was due by 12/4/17 and was not documented, making it fifteen days late at the time that employee's record was reviewed.

**Repeat Violation- Renewal December 2016.**

**R400.4147**

**Dental Care**

(2)A dental examination within 12 months prior to admission shall be documented or there shall be an examination not later than 90 calendar days following admission.

One of four open resident records reviewed did not show documentation of a dental examination within the timeframe requirement of this rule.

The resident's dental exam was due by 4/9/17 but was completed 4/12/17 making it three days late.

**Repeat Violation-Renewal December 2016.**

**R 400.4150**

**Incident reporting.**

(1) An incident resulting in serious injury of a resident or illness requiring inpatient hospitalization, shall be reported to the parent/legal guardian, responsible referring agency, and the licensing authority as soon as possible, but not more than 24 hours after the incident.

In one of four open resident records reviewed, the record documented that the resident was sent to the emergency room (ER) on 12/10/17 after hurting his finger in the gym. This information was not reported to the Division of Child Welfare Licensing as required by this rule.

**R400.4152****Initial documentation.**

At the time of admission, all of the following shall be in the resident's case record:

(c) A brief description of the resident's preparation for placement and general physical and emotional state at the time of admission.

One of four open resident records reviewed did not show documentation of preparation for placement and general physical and emotional state at the time of admission. The form used to document this information was completed on 1/16/17 however the resident was placed at the facility on 1/9/17.

(g) Authorization to provide medical, dental, and surgical care and treatment as provided in section 14a(1),(2), and (3) of 1973 PA 116, MCL 722.14a.

One of four open resident records reviewed showed the authorization to provide medical care was not completed until 12/14/17; this resident was from out of state and placed on 1/12/17.

(i) Documentation that the grievance policy was provided as required in R400.4132.

Three of four open resident records reviewed did not show compliance related to the grievance policy:

One record showed the grievance policy was provided/signed to/by the resident four days after the resident's 1/12/17 admission date. It was not clearly documented when or if it was provided to the referral source.

A second record showed the grievance policy was provided to/signed by the youth on 7/24/17 after the resident's 7/12/17 placement date.

A third record did not show documentation that the grievance policy was provided to the referral source.

**Repeat Violations- Renewal December 2016.**



**R 400.4155**

**Institutions not detention institutions or shelter care institutions; initial treatment plan.**

(1) The social service worker shall complete, sign, and date an initial treatment plan for each resident within 30 calendar days of admission.

One of four open resident records reviewed showed the resident's initial treatment plan was one day late.

**R 400.4156**

**Institutions not detention institutions or shelter care institutions; updated treatment plan.**

(1) The social service worker shall complete, sign, and date an updated treatment plan for each resident at least 90-calendar days following the initial treatment plan.

Four of five updated treatment plans reviewed were late:

Three were two, two and fourteen days late respectively per the treatment plans' completion and or signature date.

A fourth treatment plan was due by 11/6/17 and the record did not show documentation of the treatment plan, making it forty-two days late at the time of the record's review.

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**R 400.4156**

**Institutions not detention institutions or shelter care institutions; updated treatment plan.**

(2) The updated treatment plan developed by the social worker shall document input from the resident, the resident's parents, direct care staff, and the referral source, unless documented as inappropriate.

One of five updated treatment plans reviewed did not contain the resident's signature.

**R 400.4156**

**Institutions not detention institutions or shelter care institutions; updated treatment plan.**

(4) The social service worker shall sign and date the initial treatment plan.

One of five updated treatment plans reviews did not contain the social services workers' signature and date as required by the rule.

**R 400.4156**

**Institutions not detention institutions or shelter care institutions; updated treatment plan.**

(5) The social service supervisor shall approve, countersign, and date the initial treatment plan.

One of five updated treatment plans reviewed did not contain the social services supervisor's signature and date as required by the rule.

2.) Any violation listed in section 1 is also an ISEP violation. Please note that there are additional ISEP requirements that may not be included in section 1. The facility is in compliance with all additional ISEP requirements except for the following:

None

3.) Any violation listed in section 1 is also a DHHS Contract/Policy violation. Please note that there are additional DHHS Contract/Policy requirements that may not be included in section 1. The facility is in compliance with all additional DHHS Contract/Policy requirements except for the following:

**Contract-RFJJ- J- Service to be provided**

**b. Standardized Assessment Tools**

The contractor shall utilize the following assessment tools to assess the child's overall progress in functions while in the residential program:

3). Ansell Casey Life Skills or Daniel Memorial Assessment (for children 14 year of age and older).

The Contractor may utilize additional standardized and reliable assessment tools to assess overall progress in functioning. Additional program specific assessment tools required by MDHHS are identified within each Service Description in Attachment A.

The Contractor shall administer the required assessment tools until the youth is released and document the scores in MiSACWIS.

One of four open resident records reviewed did not show compliance pertaining to an Ansell Casey Life skills or Daniel Memorial Assessment:

The record did not show documentation of an initial Ansell Casey Life Skills Assessment for the resident; the assessment was due by 7/5/17 and was completed on 7/28/17. The quarterly assessment due by 10/28/17 was not documented at the time of this review.

#### **Repeat Violation-December 2016.**

#### **IV. TECHNICAL ASSISTANCE**

The facility was offered technical assistance in the following areas:

##### **R400.4113 Employee records(g)**

The agency is apprised that the written evaluation shall clearly and consistently indicate the relationship of the employee's conviction to the duties/activities of the position so as to determine employment suitability.

#### **V. CONSULTATION**

The facility was offered consultation in the following areas:

None provided during this inspection.

#### **EVALUATION OF RENEWAL PERIOD**

##### **There were sixteen complaints received by DCWL during this review period:**

Eight of the 16 complaints were investigated, and no rule violations were found in six.

Two of the 16 resulted in a rule violation and are identified below as Special Investigation 2017C0420042 and 2017C0420047. Eight of the 16 were received during or just prior to the start of this Renewal Inspection (12/9/17-12/20/17). These special investigations are in varying stages of investigation and the findings are pending.

##### **There were two incidents of substantiated child abuse and/or neglect during this licensing period:**

The first incident of substantiated child abuse and / or neglect is documented in Special Investigation 2017C042020. This investigation included allegations that a youth who had recently discharged from the facility, had a sexual relationship with a staff person. The special investigation resulted in a violation under R400.4112(1), Staff qualifications and R400.4109(1)(c), Program statement. The special investigation report and corrective action plan are pending. The staff person was terminated.

The second incident of substantiated child abuse and / or neglect is documented in Special Investigation 2017C0420042. This investigation included an allegation that a resident was hit and punched in the head by a staff person during a restraint. The special investigation resulted a violation under R400.4112(1) for Staff qualifications and R400.4158(2)(a), Discipline. The facility's corrective action plan is pending.

**The following corrective action plans were completed within this licensing period:**

1. Special Investigation, 2017C042036 was initiated on 6/15/17:

This investigation involved an allegation that resident 1 was hit in the face or head by a staff person during a restraint. Additionally, that the identified staff person told resident 3 to "beat up" resident 1. The special investigation concluded there was insufficient evidence to support the allegations however during the investigation the facility did not follow the incident reporting protocol for reporting physical management occurrences and incidents of alleged abuse/neglect. Further, the therapist Ms. Mandel, failed to report or file a Report of Actual or Suspected Child Abuse or Neglect, (DHS-3200) as required by statute. Violations were established under R400.4109(1)(c), Program statement and R400.4131 for Compliance with child protection law; development of plan required.

Citation R400.4109(1) is a repeat violation from Special Investigations 2017C0420011, 2017C0420013 and 2017C0420027 which resulted in the facility being placed on the current provisional license.

The facility's corrective action plan was submitted on 10/16/17. The plan included: all staff would receive training on incident reporting in November 2017; Ms. Mandel was re-trained on a mandated reporting on 7/19/17; the supervisor and assistant program director would review each incident report at the end of the shift for accuracy; and affirmed incidents of suspected abuse/neglect would be reported within 24-hours.

During this review period, compliance with this corrective action plan has been demonstrated by no additional citations for similar allegations to R400.4131 or R400.4109. The facility director and quality assurance risk manager verbally reported that they have reviewed all incident reports for accuracy. The risk manager provided this consultant with copies of random emails that she receives from supervisors on incident reports for the day illustrating her daily review of incident reports. The assistant director's review and correction of an incident report associated with Special Investigation 2017C0420042 also attests to the agency's compliance with the incident reporting aspect of the corrective action plan.

2. Special Investigation 2017C0420047 was initiated on 7/19/17:

This investigation involved an allegation that resident 2 tried to suffocate resident 1 on 6/22/17. The Special Investigation concluded that resident 1 should have been moved to another room following resident 2's first threat toward resident 1 to ensure resident's 1 safety. Resident 2 demonstrated aggressive and impulsive behavior regardless of attempts to implement the facility's conflict resolution intervention strategies with these residents.

The facility received a violation under R400.4127(3), Staff-to-resident ratio which was a repeat violation from Special Investigations 2017C0420011, 2017C0420013 and 2017C0420027 which resulted in the current provisional license.

The facility inadvertently did not submit a corrective action plan for Special Investigation 2017C0420047 until 12/18/17. Upon review, this corrective action plan did not adequately address the citation and an amendment was required. An acceptable corrective action plan is pending.

Special Investigations 2017C0420011, 2017C0420013 and 2017C0420027 resulted in the facility's license being modified from a regular license to a first provisional license effective 7/7/17.

3. Special Investigation 2017C0420011 was initiated on 1/19/17 and included allegations that a male resident was not properly supervised by staff, was assaulted by his roommate and received severe injuries to his face and body. The facility received violations under R400.4112(1), Staff qualifications; R400.4127(3), Staff-to-resident ratio; R400.4109(1)(c), Program statement due to failure to adhere to the facility's Room Reassignment policy; and R400.4142, Health services, policies and procedures due to a failure to dispense a resident's medication.

The agency submitted an acceptable corrective action plan on 7/6/17. The corrective action plan included the following:

- a. The supervisor and staff involved in Special Investigation 2017C0420011 were terminated for failure to follow agency policy/procedures. The facility is compliance with the action step specific to staff terminations.
- b. The policy related to room changes and approval was updated and now includes: the program director or clinical director shall authorize a room change; a face-to-face assessment shall be completed by a license clinician as part of the room change process; and random room assignment reviews would occur monthly.

The updated room change policy was reviewed as well as random Shift Report Forms. The facility amended the Shift Report form to include information such as staff/supervisory actions pertaining to

facility tour/checks, room assignments, room searches, rounds, medication pass completion, etc. A review of Shift Reports showed these checks are being documented. A review of room reassignment documents showed the room reassignment assessments are conducted by the clinical staff. The agency is in compliance with this aspect of the corrective action plan.

- c. The policy related to staffing for high risk situations was updated to require the program director or nurse manager's approval of all staffing increases; all staff were trained on the policy as of 6/16/17. In addition, all staff had been retrained on Handle with Care in March 2017 and supervisors were retrained on behavior modification in May 2017. The facility is compliant with this aspect of the corrective action plan as determined by training documentation and sign-in sheets.
- d. Ongoing training and supervision would be provided monthly to staff; supervisors would complete a ninety-day competency base evaluation on all new staff and annual evaluations to determine the staff's level of competency and identify areas of need for improvement and additional training. The Quality Assurance Department would review staff turnover rates and staff training to ensure staffing maintenance. A bench mark of less than 3% for a staff turnover rate was established; a quarterly review will occur and corrective action will be initiated if the bench mark was not met.

Staff training records and the annual/ongoing training calendar was reviewed; required and appropriate service delivery trainings did occur prior to and after the corrective action plan's submission. The facility is conducting the ninety day and annual reviews, which includes the competency scoring. Review of employee records showed timely employee evaluations. Of the performance evaluations reviewed only one employee scored in a low/unacceptable competency range; this employee was referred to an administrator for exploration of the issues. The facility's Quality Assurance Department reported a less than 3% rating for the third quarter, ending September 2017. The agency is in compliance with these aspects of the corrective action plan.

The facility continues to regularly hire staff; forty-two new staff were hired during the year.

- e. The medication policy was updated to clearly indicate: a resident's refusal of medication on the Medication Administration Record (MAR) and medical staff will ensure that residents are provided medication should he or she request the medication after an initial

refusal. The Quality Assurance department will review random sample of medical charts, monthly.

The facility converted to an electronic MAR during this review period. A sample of MARs were reviewed to determine compliance with this action step. Documentation reviewed demonstrated that medication is being dispensed as well as a resident's refusal to take the medication, discontinuation by the doctor etc. The facility is in compliance with this aspect of the corrective action plan.

4. Special Investigation 2017C0420013 included allegations that a resident was sexually maltreated by her roommate; the roommate tried to kiss the resident and grabbed her crotch; the facility was short staffed; and 24-hour supervision was not provided to the resident. The facility received a violation under R400.4127(3), Staff-to-resident ratio and R400.4109(1)(c), Program statement due to failure to adhere to the incident reporting policy.

The agency submitted an acceptable corrective action plan on 7/6/17. The corrective action plan included the following:

- a. The policy related to staffing for high risk situations was updated to require the program director or nurse manager's approval of all staffing increases. A resident's removal from close staff observation now will require approval from the attending psychiatrist.
- b. The internal "FYI" form was discontinued. Supervisors and above are the only staff to complete an incident form. The assistant program director will conduct random incident report reviews daily to ensure accuracy.

The "FYI" was not observed by this consultant during the review of random incident reports. Verification of the daily random sample review by the assistant program director was not possible during this inspection as the facility had not developed a tracking mechanism to ensure that this task was being completed. The assistant director's review and correction of one incident report related to Special Investigation 2017C0420042 was attested to. The director and Quality Assurance staff reported that the assistant director continues to perform these incident reviews as required.

The facility is in partial compliance with this aspect of the corrective action plan.

- c. The policy related to room changes and approval was updated to indicate the program director or clinical director shall authorize a room change; a face-to-face assessment will be completed by a

licensed clinician as part of the room change process; and random room assignment reviews will occur monthly. A review of room reassignment documents demonstrated that the room re-assignment assessments are conducted by the clinical staff. The facility is in compliance with this aspect of the corrective action plan.

5. Special Investigation 2017C0420027 included allegations that a resident swallowed a piece of metal in which he broke off of a heat vent in a group room. X-ray results showed he had a 6x0.5CM rectangular foreign object in his abdomen; he was sent to the hospital. The facility was found in violation of R400.4127(3), Staff-to-resident ratio; R400.4109(1)(c), Program statement due to failure to adhere to its Resident and Location Search policy; and R400.4407 Facility and premises maintenance due the broken/unrepaired room vent and stained/dirty walls that contained profanity.

The agency submitted an acceptable corrective action on 7/6/17. The corrective action plan included the following:

- a. The policy related to Searches was updated to indicate residents are to be searched as they enter/exit their bedrooms. The search would include the resident's socks; the frisk search will be updated to include the resident's hair, ears, nose, ankles/feet, mouth and under the tongue. Staff would be trained on the updated policy.

Training documentation was reviewed and documents that staff received training on the updated policy. The facility is in compliance with this aspect of the corrective action plan.

- b. Policy and procedures were developed for daily safety and security rounds to ensure that rounds are conducted regarding facility maintenance needs and concerns are reported timely to maintenance staff. A log was developed for all staff to report any concerns and "environment services" staff are to address identified concerns daily or as needed. Daily/weekly facility "walk-throughs" are to be conducted by supervisory staff. Monthly and quarterly rounds will be conducted by the Quality Risk Manager and reports provided at monthly Quality meetings.

This consultant completed a tour of the facility during the inspection; the building was observed to be free of graffiti/profanity, clean, etc. and in the process of finalizing a wall repair in the gym area. The maintenance log was previously reviewed. A random review of "walk through" maintenance logs and Shift Report forms documented environmental checks and rounds being completed



per the updated policy. It should be noted that the Shift Report form was amended to capture information such as staff / supervisory actions pertaining to facility tour / checks, room assignments, room searches, rounds, medication pass completion and other facility occurrences. The facility is in compliance with this aspect of the corrective action plan

The correction action plans for Special Investigations 2017C04020011, 207C0420013 and 2017C0420027 each include the following:

The facility will conduct random monthly and weekly reviews of incidents and reports by the Quality Assurance Department and the assistant program director. Compliance with this action step is based on the following:

- a. The Quality Assurance staff have verbally reported that such reviews are occurring.
- b. The Quality Risk Manager provided this consultant with copies of random emails that she receives from the facility; emails include incident reports for the day, illustrating her daily review of incident reports. The Quality Risk Manager has reported various resident injuries and hospitalizations timely and within 24-hours as required to this consultant
- c. Verification of daily incident report reviews and or corrections was only partially verified. As documented in Special Investigation 2017C0420042, this consultant reviewed a report which demonstrated that the assistant program director had completed a review for accuracy.

## **RECOMMENDATION**

Based on inspection findings, the facility is not in compliance with all applicable licensing statutes and rules and/or ISEP requirements and/or contract/policy. The facility has operationalized the corrective action plans and continues to move forward with the identified action steps. Given the facility's history of first provisional licenses as well as the number of special investigations and corrective action plans required during this period under review, it will be important for the facility to continue diligent and proactive efforts in maintaining and monitoring progress made thus far. Upon receipt of an acceptable corrective action plan, it is recommended that the agency's license status return to a regular license.

**Decemeber 19, 2017**

_____ Lonia Perry Licensing Consultant	_____ Date
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Approved By:

**December 21, 2017**

_____ Linda Tansil Area Manager	_____ Date
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RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

December 19, 2011

Sherri Gerber-Somers  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2012C0420006  
Detroit Capstone

Dear Ms. Gerber-Somers:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
Suite 1000  
28 N. Saginaw  
Pontiac, MI 48342  
(248) 975-5087

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2012C0420006
<b>Complaint Receipt Date:</b>	10/31/2011
<b>Investigation Initiation Date:</b>	10/31/2011
<b>Report Due Date:</b>	12/30/2011
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 28511 Orchard Lake Rd Farmington Hills, MI 48334
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2011
<b>Expiration Date:</b>	03/21/2013
<b>Capacity:</b>	66
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Resident A alleges that during an “escort” staff person, Mr. Sam, hit his head against a door and broke his tooth.

## III. METHODOLOGY

10/31/2011	Special Investigation Intake 2012C0420006
10/31/2011	Special Investigation Initiated - Telephone
11/02/2011	Inspection Completed On-site Youth and Staff Interviewed
11/02/2011	Contact - Document Received
11/07/2011	Inspection Completed On-site Agency staff interviewed, and video reviewed
11/23/2011	Comment- Exit
11/23/2011	Inspection Completed- BCAL Full Compliance

### ALLEGATION:

Resident A alleges that during an “escort” staff person, Mr. Sam, hit his head against a door and broke his tooth.

### INVESTIGATION:

On November 2, 2011, an inspection was completed on-site, and Resident A was interviewed by this consultant, and the Department of Human Services (DHS) Worker. Staff persons, Hussein Farhat (AKA Mr. Sam) Jarrell Herring and Christopher Booth were interviewed, onsite, by the DHS Worker, and this consultant on November 7, 2011:

It is noted, that Resident A was observed to have a split lower lip, which had begun to heal, and a broken center tooth. He indicated the situation started when he got upset over being questioned, by Mr. Sam for wearing a watch, and being out of his required resident's attire, during breakfast. He reported being placed in a two man hold after he threw a bowl toward Mr. Sam and attempted to attack a peer. He stated that during the escort, Mr. Sam had one of his arms, and Mr. Herring his other, and that initially he was fighting the hold, but then Mr. Sam and Mr. Herring pushed him up against the glass (window); and they signaled for staff Christopher Booth to come open the seclusion room door. Resident A indicated that on the way to the seclusion room, he threatened to swing on one of them (Mr. Sam or Mr. Herring), and they moved him up near the door way, and Mr. Sam took his (Mr. Sam's) forearm and pushed the back of his head against the wall and broke his tooth. He stated when they took him into the seclusion room, he told Mr. Booth they knocked out his tooth, and staff called the nurse.

Resident A indicated there were no other residents who witnessed the incident, and he felt that Mr. Sam's action “was intentional and there was no reason that situation should have happened” because he was no longer a physical threat to staff.

Mr. Sam and Mr. Herring both confirmed Resident's reporting pertaining to Resident A's attire, and Resident A's attempt to go after another resident, but indicated Resident A threw the bowl at Mr. Sam, and he jumped up with his fist balled. Both indicated that when Resident A went after the other resident, they physically managed Resident A.

Mr. Sam indicated telling Mr. Herring that they were going to escort Resident A to the seclusion room, and both staff reported that during the escort, Resident A hit his head/face on the door frame, of the first door prior to the seclusion room/door. Both staff also indicated holding Resident A against the wall/window at some point to gain control, signaling Mr. Booth to come open the seclusion room door, and that they did not see or hear Resident A hit his head, and were not aware Resident A had done so, or know that Resident A was injured, until Resident A was inside the seclusion room, and Resident A reported his tooth was broken. Mr. Sam reported Resident A was spitting blood; and Mr. Herring indicated seeing blood on the floor.

Mr. Sam denied pushing Resident A's face against the door, and indicated that at no time did he have his hand at the back of Resident A's head nor did he grab Resident A anywhere else except his arm. He also indicated that no other residents were around, and apart from Mr. Herring, Mr. Booth, and himself no other staff was in the area.

Mr. Herring indicated having both of his hands on Resident A's arm the entire time, and that at no time did he or Mr. Sam put a hand at the back of Resident A's head. He stated everything happened so fast and Resident A seemed calm, until he saw that he was going to the seclusion room, then he started to struggle, and at one point paused, then started to screamed. He indicated that when Resident A screamed, he was not aware the Resident A was hurt, he thought Resident A was trying to buy time to avoid going into the seclusion. He did not think Resident A intentionally hit his face against the door.

Mr. Booth reported not being present when Resident A's physical escort began. He reported that at the point he noticed Resident A being restrained "Mr. Sam and Mr. Herring had it under control" and each of them were holding one of Resident A's arms on the side. He indicated being asked to come open the seclusion room door, and reported that after he opened the second door (seclusion room door) he turned around and saw Mr. Sam and Mr. Herring bring Resident A's into the seclusion room, and Resident A had hit his face on doorway. Reportedly Resident A had blood on his mouth; was telling staff to let him go, and said Mr. Sam did this on purpose. Mr. Booth indicated he did not at any time, see Mr. Sam or Mr. Herring have their hand around the back of Resident A's neck.

Mr. Sam, Mr. Herring and Mr. Booth all reported the nurse was called, when they saw that Resident A was injured; and the nurse came and provided medical aid.

Written statements from Resident A, Mr. Sam and Mr. Herring were received and reviewed; and a video recording of the escort was viewed:

- With the exception of the statement in Resident A's written account that "Mr. Sam takes his forearm and rammed it to the back of my head. Which knocked my tooth out and busted my lip" all parties written statements were basically consistent with their verbal reporting.
- The video showed staff Mr. Sam and Mr. Herring holding Resident A against the wall, and then Mr. Booth running down to open the door. Then as Resident A is going through the door, he seemed to be struggling, and there appeared to be a pause, and then Mr. Booth entered the room followed by Mr. Sam and Mr. Herring with Resident A. Mr. Sam was seen holding Resident A's left arm and Mr. Herring the resident's right. Neither staff was seen with his hand on Resident A head or neck, at any point.

APPLICABLE RULE	
R 400.4137	Discipline and behavior management.
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of severe physical discipline inflicted in any manner.
ANALYSIS:	It evident that Resident A's mouth and tooth were injured when his head/ face apparently hit the door frame as he was being escorted to the facility's behavior management room, yet there is not sufficient evident to support the allegation that staff Mr. Sam pushed Resident A's head against the doorway causing Resident A's injuries. Resident A did struggle significantly during the restraint. The findings do not support severe physical discipline being inflicted.
CONCLUSION:	VIOLATION NOT ESTABLISHED

#### IV. RECOMMENDATION

Continuation of a regular license is recommended



December 19, 2011

Lonnia Perry  
Licensing Consultant  
Approved By:

Date



Linda Tansil  
Area Manager

12/20/2011  
Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

March 28, 2012

Sherri Gerber-Somers  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2012C0420017  
Detroit Capstone

Dear Ms. Gerber-Somers:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
Suite 1000  
28 N. Saginaw  
Pontiac, MI 48342  
(248) 975-5087

Enclosure



**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2012C0420017
<b>Complaint Receipt Date:</b>	02/24/2012
<b>Investigation Initiation Date:</b>	02/24/2012
<b>Report Due Date:</b>	04/24/2012
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 28511 Orchard Lake Rd Farmington Hills, MI 48334
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2011
<b>Expiration Date:</b>	03/21/2013
<b>Capacity:</b>	66
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

It is alleged that Youth A, sustained a broken arm, after he fell during a “physical escort” by staff, Brian Collins.

## III. METHODOLOGY

02/24/2012	Special Investigation Intake 2012C0420017
02/24/2012	Special Investigation Initiated - Telephone
02/24/2012	Contact - Document Received
02/27/2012	Contact - Face to Face Onsite visit, Spoke w/ Director, and facility nurse
02/27/2012	Contact - Telephone call made Left message for DHS Worker
02/27/2012	Contact - Telephone call received Spoke w/ DHS Worker
02/27/2012	Contact - Document Sent Faxed agency incident report and statements to DHS Worker
02/28/2012	Contact - Face to Face Detroit Receiving hospital visit-Interviewed Youth A
02/28/2012	Contact - Telephone call received Spoke w/ agency Director
02/28/2012	Contact - Telephone call made Spoke w/DHS Worker
02/29/2012	Contact - Telephone call made Spoke w/ agency Director
03/05/2012	Contact - Telephone call received Message from DHS Worker
03/05/2012	Contact - Telephone call made Spoke w/ agency Director
03/06/2012	Contact - Telephone call made Spoke w/ DHS Worker

03/06/2012	Contact - Telephone call made Spoke w/ agency Director
03/07/2012	Inspection Completed On-site Staff interviewed, video viewed
03/07/2012	Contact - Document Received
03/08/2012	Inspection Completed-BCAL Full Compliance

### **ALLEGATION:**

It is alleged that Youth A, sustained a broken arm, after he fell during a “physical escort” by staff, Brian Collins.

### **INVESTIGATION:**

On February 27, 2012, an inspection was completed on- site. The agency Director, Sherri Gerber-Somers and Nurse Shantese Jones (AKA Nurse Crockett) were interviewed. Subsequently, Youth A was interviewed at Detroit Receiving Hospital on February 28, 2012, and Youth Specialists, Darlene Jones and Brian Collins were interviewed, on- site, on March 7, 2012, by the Department of Human Services (DHS) Worker and this consultant.

Ms. Gerber-Somers reported that Youth A became upset during group therapy and threw a chair at a therapist, and staff intervened. She reported that while staff was escorting the Youth A to his room, the youth lifted his leg up against an entrance door to keep staff from egressing through the door, and youth and staff fell to the floor, resulting in Youth A sustaining a broken arm. She indicated Youth A was taken to the hospital where he remained for treatment, because the arm was broken in two places and surgery was required.

Ms. Gerber-Somers indicated Youth A said the incident was an accident, and that per her review of the video footage, staff, Mr. Collins’s execution of the physical management technique was, “textbook” and proper; and it appeared that staff and youth fell, after the youth put his leg up against the door.

Nurse Jones indicated receiving an emergency call to Youth A’s room, at which time Youth A “seemed to be in a state of shock”. She indicated he was nursing his left arm, the wrist area was visually disfigured in an S shape” and there was minimum swelling, and the skin had been scratched on the underside of Youth A’s arm. She stated she contacted the nursing manager and facility’s Operation Control Center (OCC) so that EMS could be called. She reported that at no time during her interaction and wait with Youth A did he say what happened pertaining to his injury.

Youth A reported he got upset while in group, threw a chair at his therapist, and was restrained by staff, Mr. Collins. He indicated Mr. Collins had his (Youth A) hands behind his (Youth A) back, and he (Youth A) kicked the wall, he and Mr. Collins fell down, and he hit his arm. He indicated when they fell down, Mr. Collins fell on him. He stated the incident was an accident, and that no one twisted or hurt his arm, nor did he tell anyone at the hospital his arm got twisted or hurt by staff.

Darlene Jones and Mr. Collins both reported Youth A became upset in group therapy, over getting his privilege level decreased, and that Mr. Collins intervened, after the Youth threw a chair and was walking towards the therapist. Ms. D. Jones an employee with agency for four and a half years, and Mr. Collins employed by the agency for five months, both indicated that Mr. Collins performed a proper “blindside swoop” to restrain the youth and then Mr. Collins attempted to escort Youth A to his room. Ms. D. Jones reported following along, and being present when Youth A and Mr. Collins fell. She indicated Mr. Collins had Youth A’s hands behind Youth A’s back, and Youth A became irritated and was trying to kick. She reported opening a door, and that as Youth A and Mr. Collins approached the door, Youth A abruptly kicked the wall/door entrance, causing he and Mr. Collins to fall to the floor. She indicated when the two fell Youth A said “oh my arm, that Youth A was positioned in front of Mr. Collins, and Mr. Collins was on the floor behind Youth A, who was holding his arm. Ms. D. Jones, indicated observing nothing improper about the escort; and that she called the Nurse and shift supervisor related to the incident.

Mr. Collins, whose personnel record showed his completion of behavior management training, and no disciplinary actions, reiterated Ms. D. Jones’ reporting of the event prior to the physical escort, and the incident that proceeded. He stated another staff was following as he escorted Youth A, and when the other staff opened the door, Youth A “put his foot up unexpectedly and knocked both of us back” and Youth A’s “left arm must have hit the ground”, because Youth A said “oh my arm.” He indicated he landed on his back and Youth A landed on the floor and was positioned on his left, and he helped the youth up.

A copy of an unusual incident report, post incident examination report, typed statement from Shantese Crockett, LPN, and written statements from, Ms. D. Jones, Mr. Collins, and Therapist, Tamara Tracy, as well as, patient discharge instructions were received and reviewed. Video footage of the incident was viewed on March 7, 2012:

- The unusual incident report indicated during group therapy Youth A became upset with his therapist and threw a chair at her, staff Mr. Collins and Ms. Jones intervened using the blindside swoop to physically manage Youth A. As staff escorted Youth A through the doorway Youth A used his feet to kick off the doorway, causing both Youth A and staff to fall to the floor. After getting the youth to his room, it was noticed that Youth A injured his left arm

between the wrist and mid forearm. The forearm was disfigured, the nurse quickly called and EMS was then called for further review.

- The post incident examination report indicated the nurse on staff was called to the boy's unit at approximately 2:50pm, on 2/23/2012, to assess the youth who presented with his left arm swollen, and the arm was also bent in an "S" shape. EMS was called immediately.
- The statements from Ms. D. Jones and Mr. Collins basically indicated what they reported when interviewed, as did Nurse Crockett's (AKA Nurse Jones) statement, which also indicated and that direct care staff called from the hospital to report Youth A would be spending the night, he required surgery as he sustained a break in two places.
- Ms. Tracy statement indicated Mr. Collins intervened to escort Youth A after the youth became upset and threw a chair in her direction.
- The discharge instructions indicated a surgical "irrigation and debridement" procedure was performed to the youth's left forearm, and noted the follow-up discharge directives.
- The video footage showed a group setting, a chair being throw, Youth A getting up and staff, Mr. Collins intervening. During the transport, the youth is seen struggling, and as the two approach a door, Youth A lifted what appeared to be his right leg/foot against the door, and then the staff and youth fall. Nothing unusual action or aggressive force is observed by staff.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (i) Excessive chemical, mechanical, or physical restraint.
<b>ANALYSIS:</b>	Youth A reported the incident was an accident; and both Ms. Jones and Mr. Collins indicated Youth A and Mr. Collins lost their balance after Youth A put his leg/foot up against the door to prevent egress through the doorway. Director, Gerber-Somers indicated, the physical management technique used by staff was textbook, and the video footage showed the youth struggling during the escort, no aggressive force being demonstrated by the staff, and when staff and youth approached a door entrance, Youth A lifted his leg up toward the wall/ door and both youth and staff fell to the floor.  The evidence does not support excessive physical restraint.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.



**March 21, 2012**

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Lonia Perry  
Licensing Consultant

Date

Approved By:



**March 28, 2012**

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Linda Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

May 2, 2012

Sax Guthery  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2012C0420026  
Detroit Capstone

Dear Mr. Guthery:

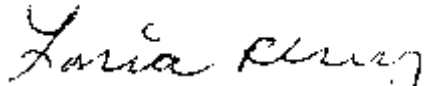
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action. You must still submit an acceptable corrective action plan.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

A handwritten signature in cursive script, appearing to read "Lonia Perry".

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
Suite 1000  
28 N. Saginaw  
Pontiac, MI 48342  
(248) 975-5087

Enclosure



**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2012C0420026
<b>Complaint Receipt Date:</b>	04/13/2012
<b>Investigation Initiation Date:</b>	04/13/2012
<b>Report Due Date:</b>	06/12/2012
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 28511 Orchard Lake Rd Farmington Hills, MI 48334
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2011
<b>Expiration Date:</b>	03/21/2013
<b>Capacity:</b>	66
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Youth A (13) alleged he and Youth B (17) had oral sex on 4/11/12, and that they did each other; he later indicated the sexual act occurred without his consent.

## III. METHODOLOGY

04/13/2012	Special Investigation Intake 2012C0420026
04/13/2012	Special Investigation Initiated - On Site
04/16/2012	Contact - Telephone call received Message from DHS Worker
04/16/2012	Contact - Telephone call made Spoke with DHS Worker
04/16/2012	Contact - Document Received
04/18/2012	Contact - Telephone call made Spoke with DHS Worker
04/19/2012	Contact - Face to Face Hawthorne Center- Interviewed Youth A
04/19/2012	Contact - Telephone call made Spoke with Clinical Director
04/20/2012	Inspection Completed On-site Interviewed Youth B and facility staff
04/24/2012	Contact - Face to Face Exit
04/24/2012	Inspection Completed –BCAL Sub Compliance

### ALLEGATION:

Youth A (13) alleged he and Youth B (17) had oral sex on 4/11/12, and that they did each other; he later indicated the sexual act occurred without his consent.

### INVESTIGATION:

On April, 13, 2012, the nature of the allegation was addressed with, the Clinical Director, Pernell Ziglor. Mr. Ziglor indicated Youth A alleged he and Youth B performance oral sex on each other; and that per Youth B, they did it to make another resident jealous. He indicated per their review of video footage the youths

are seen numerous times moving around in the room in what appeared to be an effort to avoid or be out of camera view. He reported that the youths would appear to scamper around when staff came to the door.

Youth A, was interviewed at Hawthorne Center, on April 19, 2012, and Youth B, Youth Specialists, Kyshaun Powell, Veronica Williams, Antonio Hill, and Brian Mays, were interviewed on-site, in conjunction with the DHS Worker, on April 20, 2012

Youth A reported being asked by Youth B whether he was bisexual; and him telling Youth B no. He indicated Youth B said "if you are gay show me", and Youth B "whipped out his thing". Youth A indicated "his thing" referred to Youth B's private part. He reported telling Youth B to "put that shit away" and Youth B laughed, but replied and put his private part away. He indicated Youth A came over and said "I'm so, " horny" guess what I going to do when the lights go out. He indicated Youth B distracted him by getting him to play a game of dice with paper, and moving them to a corner of the room out of the camera's view. Youth A refused to go into detail about what happened, and indicated, Youth B "tried to rape me and I said no."

Youth A reported his door was supposed to be open, due to him being on one-to-one staffing. He stated staff, Ms. Powell was his one-to one; and she was sitting at his door; but she moved and was gone for two hours. When asked if another staff replaced Ms. Powell, Youth A indicated Mr. Mays. He indicated Mr. Mays opened the door and sat down," but all the stuff had stopped" by then. When asked if he told Mr. Mays what had occurred with Youth B, Youth A indicated, he was scared and crying. He stated he told staff the next day; and his room was changed. Youth A could not recall who he reported the incident to, and reported that in January, another peer tried to pay him to suck his private part for "stuff from the store". He reported that resident shared a room with him and Youth B; and after he reported it, that resident was moved. He indicated Youth B was not moved because he was not sexually acting out.

Youth B admitted having oral sex with Youth A, and indicated the sex was consensual. He reported asking Youth A if he ever had sex with a boy, and when Youth A said yes, he asked Youth A if he wanted to have sex with him. He indicated when Youth A said, yes, he asked Youth A his preference, oral or anal sex, and Youth A said oral. He indicated when the door was closed he made sure no one was coming, they went under the camera, and he gave Youth A oral sex. He indicated later, after assuring again that no one was coming, Youth A gave him oral sex. He indicated they stopped and pretended as if they were playing card for a while, and when Mr. Mays opened the door and asked what was going on, they said they were playing cards. He stated they looked for another spot to continue the sexual encounter; and went behind the partition near the door, because that area is blocked from the camera; and then he gave Youth A oral sex again. He stated they almost got caught that time, when staff, Ms. Powell looked through the door; but it was dark, and she could not see in the room. She stated Ms. Powell did not open the door or call out to them. He indicated after they stopped, he did asked Youth A several

times to keeping going, but Youth A said no. He admitted he showed Youth A his private part and said Youth A, "he showed me his". He stated "he agreed to it, I didn't force him or anything". He said Youth A never told him to put his private part away or "put that shit away", and that when Youth A asked him to stop he did. He indicated that was when they almost got caught.

When asked who closed their room door, and how long that staff was gone, Youth B indicated Mr. Mays, closed the door, and was he was gone" a good twenty-five minutes". He indicated both he and Youth A were suppose to be on one-to one staffing, with someone sitting in their door to watch them. He indicated no particular staff person was designated for him, and Mr. Mays, Ms. Powell, Mr. Hill or Mr. Dennis would have provided the one-to-one. He indicated Ms. Powell and Mr. Mays were down the hall talking with another resident; and Mr. Dennis and Mr. Hill were 'handling another group".

Youth B indicated staff became aware of their sexual act the next day, when Youth A got mad, after he (Youth B) showed him a letter from a boy who liked him. He said Youth A got upon the partition in the room, and Youth A ended up being restrained, after which time Youth A cussed at him and then said "I raped him."

Youth Specialist, Kyshaun Powell, a one and half year employee, indicated Youth A and Youth B were in the "observation room"; but stated she was not aware Youth A and Youth B were on one-to-one staffing. Ms. Powell said she was not the assigned one-to-one staff. She reported that every staff on duty on the floor does rounds so any of the staff would have checked in on Youth A and Youth B. She reported checking in on Youth A and Youth B during her rounds, but could not recall how many times, or if she "keyed the door"(opened it), and looked in or whether the room lights were on. She stated one time she looked in the window, and saw Youth A, and asked if he was ok, and he responded yes.

She indicated "I guess I can be blamed too, didn't know the door was to be open." When asked if when residents are in the observation room, does that constitute them being under close supervision, and that the door should be open, she reported only if the facility is not full to capacity or in need of the room. She indicated she did not ask departing staff nor check the Operation Control Center's (OCC) board to find out whether Youth A or Youth B were on one-to-one staffing.

Youth Specialist, Veronica Williams a twelve year employee , reported Youth A and Youth B had been on one-to-one staffing for a few weeks, and when she checked the OCC board, the day of the incident, it indicated Youth A and Youth B were on one-to one staffing. She said she was not Youth A's one-to-one staff, but indicated she provided direct supervision to both youth for approximately fifteen minutes at the start of her shift. She reported sitting in a chair in the youths' room until she was relieved. She did not recall whom she relieved or who relieved her. She stated she thought "it was a lack of communication" with the other staff "not knowing the kids were supposed to be on one-to-one." She stated when she left for her lunch

( which she estimated was sometime between 9-9:30pm) she saw that the youths' door was closed, and she told Mr. Mays the door should not be closed, due to Youth A and Youth B being on one-to-one. She indicated Mr. Mays opened the door.

Youth Specialist, Antonio Hill, indicated being assigned one-to-one for another resident; and not being aware of whether Youth A was assigned one-to-one staffing, or whether it was indicated on the OCC board. Mr. Hill reported being three doors down and seeing Ms. Williams sitting on the youths' door sometime around 7:00pm or 7:15pm; and seeing staff person, Mr. Roberson on the youths' door before 7:00pm. He indicated not doing rounds or checking Youth A and Youth B's room, due to his one-to-one assignment, which he indicated required him to remain with that resident until he was relieved for lunch, breaks, and or shift change.

Youth Specialist, Brian Mays, reported being the assigned one-to-one staff for both Youth A and Youth B. He reported he was to sit at the door monitoring the youths' behavior until someone relieved him. He reported not being aware whether anyone relieved him for his lunch break between 7:30pm and 8:30pm; and indicated "that's where the mistake came in". He stated he closed the youths' room door to go and assist Ms. Powell with another youth. He reported that he was gone maybe twenty to thirty minutes, but indicated he could have been gone longer. When asked if anyone relieved him, Mr. Mays said "not that I remember" and indicated that there was a lot going on that day. He recalled checking Youth A and Youth B's room during the time he was away, but indicated he did not open the door. At that time, he reported seeing cards on the floor near Youth B's bed, but not much else; and that he did not see the youths on their beds. He reported returning several minutes later, at which time he said he opened the door and Youth A and Youth B were in their respective beds.

Mr. Mays confirmed that there is a blind spot near the observation room's partition that is out of the camera's view, and a resident could move to that area and not be seen by the camera. Mr. Mays stated "but if I am sitting at the door I can see them".

On April 20, 2012, the Clinical Director, Pernell Ziglor confirmed that Youth A and Youth B were both on one-to-one staffing the day of the incident. Mr. Ziglor had also been advised to contact the police related to the sexual allegation; and he reported the police had been contacted.

#### **Reviewed:**

Incident report, dated April 12, 2012, which indicated:

- During bedtime Youth A reported that on April 11, 2012 Youth B performed oral sex on him.
- The youths were quickly separated; and upon investigation, there was no visible evidence to confirm or rule out any act of sexual misconduct.
- Youth A bragged to staff about the sexual act.

Video footage which showed:

- Youth A and Youth B moving about the room at varies times; and the room's door closed between 7:00pm and 8: 25pm. At various times, the youths appearing to look into the camera, and then one youth would go off camera, and then the other, and at time both would go off camera.
- Youth A appearing to check the door at various times: and early on, during the stated time period, the youths seen sitting on the floor appearing to playing card.
- At 7:05pm the youths' room opened, the light appeared to be on; someone looked in, and then closed the door.
- At one point between 7:21pm- 7:37pm Youth A and Youth B, at different seconds in times, appearing to be on their knees; and they go back and forward behind a partition in the room. At about 7:39pm both youths appeared to be behind the partition and remained behind it for two and a half minutes; then went to their respective beds.
- The youths going off camera gain at about 7:50pm for a minute and then at about 8:00pm, the youths' heads came together, as if kissing.
- At 7:46pm someone appeared to come to the door, but the door did not open.
- Mr. Mays in the hall way letting another resident into his room, and him on and off the unit at various times. At 8:25pm the youths' door was observed open; and Mr. Mays was seen seated at the door.

Suicide & Self harm prevention and management policy which indicated

- One-to-one staffing as an intensive monitoring process whereby the individual on one-to-one will remain within arm's length of staff at all times.
- The observation room is "A room used to monitor residents exhibiting at risk/suicidal thoughts/ideations/gestures/attempts."
- "One staff member shall be responsible for monitoring no more than 3 at-risk/suicidal residents during sleeping hours in the observation room."
- "The door to the observation room must remain open at all times."

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(2) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.

<b>ANALYSIS:</b>	<p>Violation of this rule is established</p> <p>Youth A, Youth B both reported being on one-to-one staffing, and this was confirmed by staff, Mr. Ziglor, Ms. Williams, and Mr. May.</p> <p>Ms. Williams and Ms. Powell reported and or acknowledged observing Youth A and Youth B in the observation room and that room's door being closed, at some point, the night of the incident; and Mr. May admitted he closed the observation room door. He also admitted he was the assigned one-to-one staff for both youths, and that he was away from the observation room, and his assigned one-to-one responsibilities for 20- 30 minutes. Additionally, video footage showed the youths' room door closed; Mr. Mays leaving the unit at various times; and no staff sitting or standing at Youth A and Youth B's door between 7:00pm and 8:25pm.</p> <p>Youth A and Youth B were in the observation room and placed on one-to-one staff; and the observation room door was not kept open at all times, and nor were staff present in front of the youths' door at all time as mandated by policy. Therein, the agency did not follow its one-to-one staffing procedure and suicide &amp; self-harm prevention and management policy and procedure, and it did not assure the continual safety and protection, and direct care and supervision of the residents.</p>
<b>CONCLUSION:</b>	VIOLATION ESTABLISHED

#### IV. RECOMMENDATION

Upon submission of an acceptable corrective action plan, continuation of a regular license is recommended.



April 27, 2012

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



May 2, 2012

\_\_\_\_\_  
Linda Tansil  
Area Manager

\_\_\_\_\_  
Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

July 10, 2012

Sax Guthery  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2012C0420038  
Detroit Capstone

Dear Ms. Guthery

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

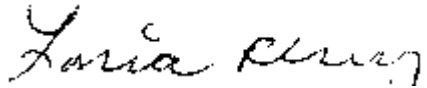
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.



Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

A handwritten signature in cursive script that reads "Lonia Perry".

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
Suite 1000  
28 N. Saginaw  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2012C0420038
<b>Complaint Receipt Date:</b>	05/30/2012
<b>Investigation Initiation Date:</b>	05/31/2012
<b>Report Due Date:</b>	07/29/2012
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 28511 Orchard Lake Rd Farmington Hills, MI 48334
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2011
<b>Expiration Date:</b>	03/21/2013
<b>Capacity:</b>	66
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Resident A has a bruise on his right eye, and a busted lip, which was reportedly caused by a staff. Resident A however said he got the injury when he was fouled playing basketball. Later Resident A said it was due to him and Mr. Mohamed "horse playing".

## III. METHODOLOGY

05/30/2012	Special Investigation Intake 2012C0420038
05/31/2012	Special Investigation Initiated - Face to Face
05/31/2012	Contact - Face to Face Interviewed Resident A, Resident B, Staff, T. Clay, and H. Mohamed
06/01/2012	Contact - Face to Face Spoke with clinical Director, P. Ziglor
06/01/2012	Contact - Telephone call made Left message fro DHS Worker
06/11/2012	Contact - Telephone call made Attempted contact with staff, J. Taylor, unable to leave message
06/11/2012	Contact - Telephone call made Left message for staff, M. Holmes
06/12/2012	Contact - Telephone call made Attempted contact with staff, J. Taylor, unable to leave message
06/13/2012	Contact - Telephone call received Message from M. Holmes
06/13/2012	Contact - Telephone call made Spoke with staff, M. Holmes
06/22/2012	Contact - Face to Face Spoke with staff, J. Taylor
06/22/2012	Comment- Exit
06/22/2012	Inspection Completed- BCAL Sub-Compliance

**ALLEGATION:**

Resident A has a bruise on his right eye, and a busted lip, which was reportedly caused by a staff. Resident A however said he got the injury when he was fouled playing basketball. Later Resident A said it was due to him and Mr. Mohamed "horse playing".

**INVESTIGATION:**

Resident A denied being intentionally hurt by staff. Resident A reported he and Mr. Mohamed were in his (Resident A) room, and no other residents or staff were present. He said his roommate Resident B was left in the activity room, and when Mr. Mohamed took him to the room, he and Mr. Mohamed talked about who could beat whom wrestling; and they started horsing playing. He indicated they played around for a minute or so, and at some point during the horse play, Mr. Mohamed's hand came down on his eye and scratched his eye. He said "Mr. Mohamed did not do it on purpose"; and that Mr. Mohamed apologized for hurting his eye. It is noted, that at the time of this interview, Resident A had a moderately healed scratch on his right eye.

Resident A reported not knowing how his lip got injured, and indicated Mr. Mohamed alerted him to his hurt lip. Resident A speculated he may have hurt his lip while wrestling, or that it may have come from him always biting his lip. He reported seeing a nurse the next day, at which time a body graph and x-ray occurred. He indicated he did not think he needed to see a nurse after the incident, and he did not know why Mr. Mohamed did not call for a nurse after the incident.

Resident B denied being a witness to what Resident A reported occurred in his room, and indicated Resident A never told him what happened. He said he never witnessed any staff horse playing with Resident A.

Resident B indicated a nurse examined Resident A's eye yesterday, and at that time, he heard Resident A tell Mr. Dawson, and Nurse Baker, that he (Resident A) got fouled in basketball and got scratched while playing basketball in the gym.

Youth Specialist, Tony Clay reported that on Monday, May 28, 2012, Resident A already had a small scratch on his eye. He indicated he took Resident A to his room from the activity room, due to Resident A being upset, and Resident B was not in the room. He reported he was talking to Resident A, and then Mr. Mohamed came to the room, and was talking to Resident A, trying to cheer Resident A up. Mr. Clay reported returning to the activity room; and that 5 to 10 minute later Mr. Mohamed came back to the activity room. He indicated that at no time while he and Mr. Mohamed were in Resident A's room did any wrestling or horse playing occur, and that he did not witness any other staff entering Resident A's room or wrestling or horse playing with Resident A. He indicated various residents had been trying to get Mr. Mohamed fired, and speculated this complaint may also be connected to that attempt.

Youth Specialist, Hammoud Mohamed, collaborated Mr. Clays' accounting; and reported he and Mr. Clay walked Resident A to his room. He indicated he went into the room for several minutes, and he tried to talk/ joke with Resident A to cheer him up, due to Resident A being upset over being locked up for the holiday. Mr. Mohamed denied wrestling, horse playing or injuring Resident A's eye or lip. He reported not observing anyone else going into Resident A's room; or horse playing with him during his( Mr. Mohamed) shift.

Mr. Mohamed reported noticing a scar on Resident A's eye, and indicated not being sure how it got there. He indicated the mark looked bad, and looked infected the next day. He said Resident A told him the injury was the result of a basketball accident in the gym, but Resident A did not report any further details. He reported he did not call the nurse, because he assumed it had already been taken care of.

Youth Specialists, Marcus Holmes, and Jeremiah Taylor both indicated Mr. Brian Mays was in Resident A's room horse playing with Resident A on the holiday; and that the injury to Resident A eye was not caused by Mr. Mays, did not occur doing that time. Mr. Holmes said the mark on Resident A's eye was already there, and Resident A did not complain about the eye. Mr. Taylor indicated Resident A had a mark on his eye which looked old/not like it had just occurred because it had a little scab on it.

Reviewed incident report dated 5/29/12, which indicated:

- During am medication pass, nurse, Patricia Smoot noticed Resident A had a scratch next to his right eye, as well as, the appearance of a busted lip.
- Resident A reported he hurt himself playing basketball in the gym.
- Later Resident A alleged that on 5/28/12 he was wrestling with staff in his room and received the scratch and busted lip.

<b>APPLICABLE RULE</b>	
<b>R400.4137</b>	<b>Discipline and behavior management</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of severe physical discipline inflicted in any manner.

<b>ANALYSIS:</b>	<p>The evidence does not support severe physical discipline.</p> <p>There was initial conflicting information as to when and how Resident A sustained the injury to his lip and eye; but Resident A reported his eye was accidentally scratched by Mr. Mohamed; and he speculated he may have hurt his lip by biting it, or during the same time of his voluntary horse/wrestling play with staff Mohamed. He denied being intentionally injured by staff.</p> <p>Additionally, Resident B and Mr. Mohamed indicated Resident A reported his eye injury occurred while playing basketball in gym; and staff, Mr. Holmes and Mr. Taylor both indicated Resident A injury to his eye was not fresh/was already healing at the point Resident A was involved in horse play activities with Mr. Mays.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **ADDITIONAL FINDINGS:**

During the course of the investigation it was discovered the agency was in violation of its Staff Boundaries policy.

#### **INVESTIGATION:**

Clinical Director, Pernell Ziglor reported Mr. Mays, Mr. Holmes and Mr. Taylor all initially said they were just talking with the residents, and upon further internal investigation all, but Mr. Mays acknowledged that horse play did occur. Mr. Ziglor indicated each staff was disciplined.

Youth Specialists, Marcus Holmes, and Jeremiah Taylor both indicated Mr. Brian Mays was in Resident A's room horse playing with Resident A on the holiday.

Both also reported not witnessing anyone else wrestling or horse playing with Resident A, but reported overhearing, through word of mouth, of an incident involving Resident A with Mr. Mohamed.

Mr. Holmes reporting observing Mr. Mays in Resident A's room from the door, and that the horse playing went on for about two minutes.

Mr. Taylor reported Mr. Mays yelled for him to come to Resident A's room, and when he entered Resident A was laying on his side and Mr. Mays was standing over Resident A. He said Mr. Mays had his hands on Resident A's shoulder and both Mr. Mays and Resident A "were smiling, and it seemed like they were wrestling, I didn't like what I saw and I left out of the room." He indicated Mr. Mays left the room when he left, and although they did not talk about what occurred, "it looked like they had been horse playing at the time."

Viewed/Reviewed:

Video Camera Recording, which showed:

- Various comings and goings to Resident A and Resident B's room between 1:54pm and 2:59pm.
- Mr. Mohamed and Mr. Clay at the residents' door, and Mohamed entering the room and coming out shortly thereafter.
- Both Resident A and Resident B being put into the room.
- Mr. Mays entering the residents' room at about 2:35pm, while both residents are inside; and then shadow movements occurring, and what appeared to be arms swinging. That activities going on for a few minutes, and then Mr. Mays and Resident B exiting the room and both appearing to be smiling. Shortly thereafter Mr. Taylor and Resident B entering the room, and again, shadow/bouncing movements seen.
- Mr. Mays and Mr. Taylor in the room together, then both exit, and go down the hall; and a minute or so later Mr. Mays going back into the room, followed by Mr. Holmes. Once again swinging of some of type, and shadow movements are seen.
- Mr. Mays and Mr. Holmes smiling and appearing to be laughing as they come out of the room, then Mr. Mays looking into the door and appearing to laugh.

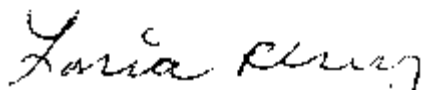
Staff Boundaries Policy which indicated:

- Prohibited activities and relationships that are indicative of an unprofessional boundary relationship include but are not limited to the following:
- "... Engaging in any physical horseplay or contact (unless part of a behavioral intervention such as Handle with Care)."

APPLICABLE RULE	
<b>R400.4109</b>	<b>Program statement.</b>
	(1) An institution shall have a current program statement which specifically addresses all of the following: (c) Policies and procedures pertaining to admission, care, and discharge of residents.
<b>ANALYSIS:</b>	Mr. Holmes, and Mr. Taylor, both indicated Mr. Mays was engaged in horseplay with Resident A, and the video recording showed some type of staff/ resident play occurring during the times Mr. Mays, Mr. Holmes and Mr. Taylor were in Resident A and Resident B's room.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan continuation of the facility's current licensing status is recommended.

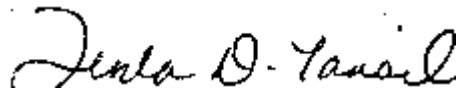


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Lonia Perry  
Licensing Consultant

Date  
**July 7, 2012**

Approved By:



July 10, 2012

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Linda Tansil  
Area Manager

Date





RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

October 17, 2012

Sax Guthery  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2012C0420044  
Detroit Capstone

Dear Mr. Guthery:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonina Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
Suite 1000  
28 N. Saginaw  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2012C0420044
<b>Complaint Receipt Date:</b>	07/03/2012
<b>Investigation Initiation Date:</b>	07/03/2012
<b>Report Due Date:</b>	09/01/2012
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 28511 Orchard Lake Rd Farmington Hills, MI 48334
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2011
<b>Expiration Date:</b>	03/21/2013
<b>Capacity:</b>	66
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Allegation 1(A Department of Human Services (DHS) Worker was involved related to this allegation)

The facility ran out of food, and when Youth A stood up and complained about it, a staff picked him up by his broken arm, slammed him to the floor, torn his shirt and bruised him up.

Allegation 2

Youth A should have been receiving special education services, and he was not.

Allegation 3

The facility does not give Youth A all his medications.

Allegation 4

The Facility has roaches and bedbugs.

It is noted that the following allegations were also made:

- Youth A arm broke his arm in two places, and was sent to the hospital twice.
- Youth A was bullied by another youth in the bathroom, and Youth A got mad and punched the wall and that's how he broke his arm.
- Staff Mr. Mays asked Youth A's mother for \$50 for Xanax pills and has been fired a couple of times from Capstone.

Each of these allegations was addressed in a prior special investigation reports. Bulletin point one and two were addressed in special investigation report 2012C0420043; and at that time Youth A denied being bullied, medical documentation indicated Youth A had a finger contusion, not a fracture which was sustained from him purposefully hitting a wall. The evidence did not support a lack of protection, and direct care and supervision of the resident.

Bulletin point three with respect to Mr. Mays allegedly seeking to purchase Xanax pills from the youth's mother was addressed in special investigation report 2012C0420029; no substantiation to the Staff qualification rule was noted at that time. It should also be indicated that review of Mr. Mays' personnel documents showed Mr. Mays met the qualifications for a Youth Specialist, had a three day suspension discipline action in April 13, 2012, was terminated for wrestling with a resident June 1, 2012, and was subsequently rehired after the facility's reassessed the situation. Additionally, and prior to the writing of this report, the Clinical Director, Mr. Ziglор reported Mr. Mays resigned his position, and is no longer an employee at the facility.

Therein, the bulletin allegations were not addressed/re-assessed within this special investigative report.

### III. METHODOLOGY

07/03/2012	Special Investigation Intake 2012C0420044
07/03/2012	Special Investigation Initiated – Telephone
07/03/2012	Contact - Telephone call made Spoke with complainant
07/03/2012	Contact - Document Received Incident report.
07/05/2012	Contact- Telephone call received Spoke with DHS Worker
07/05/2012	Contact - Face to Face Interviewed Youth A, Youth A's Mother, and agency staff
07/05/2012	Contact - Document Received Medical/medication documents
07/09/2012	Contact - Face to Face Interviewed Youth B and staff
07/10/2012	Contact- Face to Face Residents and staff interviewed
07/12/2012	Contact- Telephone call made Spoke with Youth A mother, attempted contact with Youth A
07/13/2012	Contact- Telephone call made Spoke with Youth A
09/04/2012	Inspection Completed- BCAL Full Compliance

#### ALLEGATION:

The facility ran out of food, and when Youth A stood up and complained about it, a staff picked him up by his broken arm, slammed him to the floor, torn his shirt and bruised him up.

It is again noted that a DHS Worker was involved related to this specific allegation.

#### INVESTIGATION:

The complainant was interviewed by telephone, on July 3, 2012, at which time she expressed concern that Youth A was not being treated right. She said the facility ran out of food and Youth A spoke out about it. She said Youth A stood in a chair and said “we

are not dogs here, you need to feed us more than just rice”; then one staff picked up Youth A and threw him to the ground tearing Youth A’s shirt and bruises his face and shoulder.

The complainant reported to have picture of said bruises, but did not provide such to this consultant. She said the facility ran out of food, because they didn’t bring enough, and then they later ordered a pizza.

Clinical Director, Pernell Ziglor, was interviewed on July 3, 2012 and again on July 5, 2012. He indicated Youth A, Youth C, and Youth D along with one other resident was trying to start a problem in the cafeteria. He said Youth A was trying to incite a riot, and he had to be removed from the room. Per Mr. Ziglor Youth A did not want to wait for his meal, said “I’m no fucking dog”, came up on staff, would not follow directives, and he was restrained.

Mr. Ziglor acknowledged that there was a food supply shortage on July 2, 2012 at dinner, and that the Director, Mr. Guthery addressed the incident, and ensured that all residents received a full meal.

Youth A, Youth A’s Mother, Director, Sax Guthery, Administrative staff, Carita Brown, and Life Skill manager/ Transportation Coordinator, Irahim Dakhilallah(Mr. Abe) were interviewed on July 5, 2012.

Youth A when interviewed on July 5, 2012, indicated that during dinner on “Monday or Tuesday servings of food ran out, and no meat, just rice and string beans” were left. He said when the rice and string beans were given to him, Mr. Pryor said they ran out of meat, don’t get mad. Youth A reported being unsure if the facility knew beforehand that enough food was not delivered. He indicated he got mad, stood up and said “we are not dogs”, then he tried to go talk to Mr. Pryor, but Mr. Dennis told him no, and to sit down. Youth A indicated he said he “was not going to eat the crap”, and when Mr. Dennis told him to sit down he “play like said no” then Mr. Dennis picked him up, slammed him on the table, picked him up and pushed him toward the white board, and his(Youth A) face hit the board.

Youth A indicated when he was restrained his arms were behind his back, and his right knee hit the table stool; and he later went to the hospital. He said he had a contusion and was told to put ice on it and to take Motrin. He indicated Youth C, Youth D, and another youth witness the incident.

Youth A’s mother was interviewed on July 5, 2012, and she reported being informed by Youth A that he was only given rice, and that when he complained, staff picked him up and pushed him to the floor. She indicated Youth A “said they promised they were going to order pizza” once they were out of food”.

Youth A’s Mother reported she went to the hospital, related to Youth A; and he had a bruise on his right knee, redness on the left side of his neck, and his t-shirt was torn.

Youth A's Mother had her relative, to show this consultant the pictures of Youth A from her phone. Redness was seen on Youth A's knee and the back of his neck. It is not known when the pictures were taken; and Youth A's Mother relative indicated she would send a copy of each picture to this consultant, but copies were never received.

Director, Sax Guthery indicated staff and residents were a part of the service team that day, and the server gave out too much food. He indicated by the time it came for the last two groups to be served, they had run out of meat, but had rice, string beans and potatoes. He said the staff alerted him to the issue, and he sent staff out for pizza to complete the meal.

Mr. Guthery indicated the food shorty that day was not a normal occurrence. He indicated such an incident may have occurred one other time since his employment, and they always ensure that the residents are fed. He indicated the facility has frozen dinners, and also McDonald cards available in case of emergency, so no child would ever go without.

Per Mr. Guthery the Salvation Army supplies everything the facility needs regarding supplies; and alternative meals are provided for residents with allergies or cultural restrictions. He said Capstone emails Salvation Army their client census weekly, to aid in accurate daily meal deliveries. Mr. Guthery said Mr. Abe works with the Salvation Army, and reviews the daily supply of food with the Salvation Army's delivery staff.

Ms. Brown indicated the facility's weekly menu, along with the number of residents in placement is email to the Salvation Army by Mr. Abe; and that many times the Salvation Army sends extra food.

Mr. Abe reported sending their food supplier, the Salvation Army the agency's menu on Friday for the upcoming week; and the census every Monday. He said three meals are served daily, plus a snack. He reported meeting with the food delivery staff regularly to try to ensure that there is enough food for the three daily deliveries from the Salvation Army. He indicated when the Salvation Army "brings individual stuff it easy for us to count and ensure it's enough" but when they deliver "trays of food, we ask if it's enough" and trust that they have provided enough, which usually is the case. He said there not being enough food rarely happens; and when they know the food is short, he can contact Salvation Army, and Salvation Army will bring more food.

Therapist, Tamara Tracy, and Youth Specialists, Christopher Purnell, Orice Dennis, and Dewayne Fields were all interviewed on July 9, 2012, by this consultant, and the DHS worker. Youth B was also interviewed July 9, 2012, by this consultant only. Youth C, and Youth D were interviewed by this consultant and the DHS Worker on July 10, 2012; and Youth E, Youth F, Youth G, as well as, Youth Specialist, Brandon Childs were interviewed on this same date by this consultant only.

Mr. Purnell, Mr. Dennis, Mr. Fields, and Mr. Childs each reported it is not normal for the facility to run out of food. Mr. Purnell indicated it "being a portion thing" and the servers

may have given out more portions than they should have, causing the shortage for the other resident groups. He said substitute food, like peanut and jelly are kept on-site in case of emergency. Mr. Dennis and Mr. Child said they have run out a few other times, but substitutes are provided. Mr. Dennis said the shortage was whereby the Salvation Army got the resident numbers incorrect, then Capstone called them, and the Salvation Army brought something over right away. Four of the six youths interviewed, aside from Youth A, reported the food ran out when they got to group C, and Group D; and all indicated the food is enough or enough to get them to the next meal.

All staff and youths interviewed reported the facility ran out food that day, in that they ran out of meat, and only vegetables were left. All interviewed indicated Youth A became upset, said something to the affect “ I ‘m not a fucking dog, don’t feed me like a fucking dog”, as report by Ms. Tracy, or “what is this shit I’m not a fucking dog” as reported by Mr. Dennis or wording close thereof. All youths and staff interviewed, also indicated pizza was obtained for the resident to have a complete meal, and that the pizza arrived within a fifteen to forty-five minutes timeframe.

In terms of Youth A’s restraint, Ms. Tracy, and Mr. Purnell both indicated Youth A cussed about the food, refused to sit down when given directives by Mr. Dennis, walked up on Mr. Dennis and was physically managed by Mr. Dennis. Per Ms. Tracy and Mr. Purnell the restraint, a blind side swoop, was performed properly. Ms. Tracy said Mr. Dennis, grabbed the youth’s arm and had him against the table, Youth A’s chest was against the table, and Youth A was struggling. Mr. Purnell said the upper part of Youth A’s body was on the table, and his lower body was on one of the round stools. He said he did not witness Youth A’s leg or body hit the stool, and that he did not see or hear Youth A’s body hit the table, that he just heard Youth A cussing.

Mr. Dennis reported trying to get Youth A and the other residents calmed down, he was trying to reassure Youth A that more food would be obtained, but Youth A “ just flipped out” and would not calm down. Reportedly Youth A was threatening to get staff fired, and to call his lawyer. He said he had given Youth A a couple of directives to sit down, then Youth A tried to go pass him, and he restraint Youth A using a blind side swoop. He said as he turned to swoop, he leaned the youth on the table, he did not take the youth to the floor, and the youth’s face never hit the table. He said Youth A was struggling; and as he was leading Youth A to the door, he had to lean Youth A against the board, but that he never forced Youth A’s face or any part of Youth A’s body against the board. He reported holding Youth A arms not his head or neck.

Ms. Tracy, Mr. Purnell and Mr. Dennis all reported not noticing any marks or bruises to Youth A; and per Ms. Tracy Youth A did not complain of being hurt. However, per Mr. Purnell after the restraint, Youth A complained about his leg hurting, and the nurse got a wheel chair for Youth A. Per Mr. Dennis, sometime after the restraint Youth A complained about his knee, said he (Youth A) bumped his knee, his leg was broken, and that he could not walk, but when Youth A came from the hospital, he was walking fine.

Mr. Fields, reported not witnessing the restraint, he observed Youth A in the hallway, at which time Youth A complained of his leg hurting. Mr. Fields reported being present when the nurse came, and that Youth A was sent out for medical examination.

Youth B reported not witnessing the restraint.

Per Youth C, Youth A was restrained by Mr. Dennis, Youth A had no noticeable marks or bruises; and Youth A did not appear hurt. Youth C said “it was a good restraint” that Youth A was “just grabbed by the arms” and they were put behind his back “like a regular restraint” that Mr. Dennis “didn’t slam his head or nothing”.

Youth D reported Mr. Dennis threw Youth A on the table, then threw him up against the wall, with Youth A’s hands behind his back. He said Youth A hurt his leg on the seat. He said Youth A told Mr. Dennis he was going to sue him, but Youth A didn’t tell Mr. Dennis anything about his leg.

Youth E reported Mr. Dennis grabbed Youth A because Youth A threw his plate and refused to sit down. He said Mr. Dennis performed a blind side swoop, had Youth A on the table, then put him against the wall, then slammed him on the table, and he heard a boom. Youth E said Youth A’s hands were behind his back.

Youth F said he did not see Youth A get restrained; and Youth G indicated he did not see the beginning of the restraint. Youth G said Youth A was yelling and trying to get staff to do something about the food situation, but he never saw Youth A go toward Mr. Dennis. He said when he looked Mr. Dennis had Youth A over the table and Youth A’s hands were behind his back. He said the side of Youth A face was on the table, but Youth A was not slammed. Youth G said in his opinion things got out of control, and although he hates getting restrained, a restraint was called for. He reported not seeing Youth A get escorted out nor seeing him being pushed into a wall, because staff had taken him/them out of the cafeteria.

#### Reviewed:

- A Receipt for pizza dated July 2, 2012.
- Incident report dated July 2, 2012, which indicated Youth A complained about his dinner, began to disrupt the group, got up from his seat, ignored staff’s directive, invaded staff’s personal space, shoved staff aside, and was physically managed. The report indicated the nurse assessed the youth and he was taken to the ER for x-rays.
- Video footage of the cafeteria incident/restraint on July 2, 2012, which showed Youth A walking around a table, Mr. Dennis appearing to point at the youth, then Youth A walking upon Mr. Dennis, Mr. Dennis putting his hand out as if to gesture, then Mr. Dennis was holding Youth A, and they appeared to be up against a table. The two straighten up, Mr. Dennis escorted Youth A toward the door, Mr. Dennis was behind Youth A, whose hands were behind his back, and the two came close to a board, which was near the door, but at no time did Youth



A's face or body come in contact with the board. Other staff were seen getting the other residents out of the cafeteria.

- Children Hospital of Michigan- Emergency Discharge instruction and Capstone Medical Offsite Encounter form, both indicated a contusion to the knee and recommended ice. The latter also recommend Motrin for pain.
- Capstone's Menu for July 2- July 8, 2012;, which showed the listed Monday, July 2, 2012 meal as Swedish meatballs, noodles, and mix vegetables. Rice, string beans, and potatoes are not listed for this meal.

<b>APPLICABLE RULE.</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (i) Excessive chemical, mechanical, or physical restraint.
<b>ANALYSIS:</b>	Youth A was restraint due to extreme behavior, he fought against the restraint and hit his leg or knee against a stool and medical attention was sought. The evidence does not support excessive physical restraint,
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4169</b>	<b>Resident nutrition.</b>
	(1) A licensee shall provide a minimum of 3 nutritious meals daily unless medically contraindicated an documented
<b>ANALYSIS:</b>	By all accounts the facility ran out of meat for several residents' dinner, on the day of the incident, and pizza was obtained and provided. A meal was not missed; and per most accounts, aside from a couple of food supplier delivery mishaps, this incident was not a normal occurrence ; and that the food provided is enough or enough to get to the next meal.  <b>Technical Assistance</b> With respect to subrule (2) of this rule: documentation of any changes or substitution to the menu must be consistently documented on the said menu.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **ALLEGATION:**

Youth A should have been receiving special education services and he was not.

#### **INVESTIGATION:**

The complainant indicated on July 3, 2012, per telephone contact, that she was informed Capstone was not providing Youth A a proper education. The following staff

were interviewed related to the allegation, Youth A's mother and Clinical Director, Pernell Ziglor, on July 5, 2012, Educational Director, Brian Serafino on July 9, 2012, Therapist, Jamie Thomas on July 10, 2012; and Youth, by telephone, on July 13, 2012 :

Youth A's Mother reported, therapist Ms. Thomas did not put Youth A in special education until the last week that he was there. She indicated there was an IEP last month (June) and the special teacher indicated he just saw the IEP papers two weeks ago. She said she had a meeting with everyone last month and no one knew Youth A was in special education.

Mr. Ziglor reported that prior to Youth A's discharge on July 5, 2012, in addition to Youth A receiving individual, group and family therapy, he received educational tutoring services both via Capstone, and the Central Care Management Organization(CMO) Starrvista. He indicated Youth A was said to be emotionally impaired, and that Capstone's educational classrooms are small, and representative of what is offered in community special education class rooms;

Mr. Serafino reported children with emotional impairment special education classification are automatically accompanied in the facility's education program, as their classrooms are smaller and if the child required breaks and tutoring, then those services are provided. He said if the child came into the program with an IEP that plan is adapted into the child's education plan. That if no IEP is received at the child's placement, and they are informed one was done, Capstones tries to secure that plan from that last school the child attended, but often that is difficulty to obtain. Also that if warranted, Capstone will do a new IEP. Mr. Serafino reported being uncertain of Youth A's exact specifics; but indicated he would check and fax or email any specific data. When Mr. Serafino was asked about any additional information related to Youth A, by way of Mr. Ziglor, Mr. Serafino reported not having any additional information to share.

Ms. Thomas, reported being Youth A's therapist since March 2012, shortly after his February 27, 2012, Capstone placement. Ms. Thomas said she had nothing to do with special education, nor did she know how Capstone went about getting a resident's prior school records. She indicated, Youth A had complained of difficulty in his classes, and said he was struggling because he believed the classes were general classes. She indicated Youth A always had access to a tutor via Capstone, but she was not sure if he was getting it. She said she requested additional tutoring for Youth A via the CMO, and the services began the next day. She indicated a June 11, 2012 IEP came about after Youth A's Mother dropped off IEP documents, sometime in May, and per contacts from the CMO worker to Mr. Serafino. She said the special education teacher, Mr. Z was in attendance at the IEP meeting and; he informed Youth A and Youth A's mother, he was able to assist Youth A in all his classes.

Youth A reported having six classes while at Capstone, and that he "was doing good", He said he had some difficulties in his math and science classes; and that Capstone knew he was struggling. He reported being in a classroom with ten other residents and that he did not know if they were getting tutoring in groups, but he got tutoring from

Starrvista for a few weeks before he left Capstone. He said Mr. Serafino never talked with him about special education, but Mr. Ziglisku(Mr. Z) told him he was in special education, because of the environment/ the smaller classroom.

Review of Youth A's file showed:

- A psychological evaluation report dated 1/31/12 indicating Youth A stated he was, at that time, currently enrolled in 10<sup>th</sup> grade at a community High School. "He noted that he has participated in special education programming (Emotionally Impaired) for the past two years and repeated the 9<sup>th</sup> grade.
- The 1/31/12 psychological assessed Youth A with a full Scale IQ of 84 within the low average range of cognitive functioning. Tutorial support was recommended.
- A Release to obtain school record from Youth A's last school.
- An Initial Residential Treatment Plan and Updated Residential Treatment Plan that documented Youth A prior education involvement, with the education section documenting " yes:" for special education, and emotionally impaired listed as the classification.
- April, May and June 2012 progress reports for Youth A showing overall average to good progress, as well as, some D and E grades for Earth science; and notations of the youth's need to focus more.
- An Individualized Education Program Team Report dated 6/11/12, and attached IEP team reported dated 4/15/11, both reports documenting Youth A classification as Other Health Impairment.

Review of Capstone Educational Services policy indicated " Teachers and aides provide a classroom ratio no greater than 1:15 for general education and all special education students are mainstreamed into regular class setting."

<b>APPLICABLE RULE</b>	
<b>R 400.4144</b>	<b>Education</b>
	(2) Provision shall be made for an appropriate education program in accordance with Act No. 451 of the Public Acts of 1976, as amended, being S380.1 et seq. of the Michigan Compiled Laws, and known as the school code of 1976, not later than 5 school days after admission and continuously thereafter for each resident of school age.
<b>ANALYSIS:</b>	The evidence indicates Youth A was provided an appropriate education program in that he was placed in a small classroom, tutoring services were offered and provided; he was mainstreamed into a regular class setting, and upon subsequent obtainment of prior IEP documentation, an updated IEP was held.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

The facility does not give Youth A all his medications.

**INVESTIGATION:**

The complainant indicated on July 3, 2012, per telephone contact, that Capstone does not give Youth A all his medication, nor gives him his ADHD medication on time. The following staff were interviewed related to the allegation, Youth A's Mother and Nurse, Patricia Smoot on July 5, 2012; and Youth A, by telephone, on July 13, 2012:

Aside from indicating that her son has an Attention Deficit Hyperactivity Disorder (ADHD) and is Bipolar Youth A's Mother did not indicate a concern in this area.

Nurse, Smoot reported, Youth A was diagnosed with ADHD, Conduct Disorder, Mood Disorder and Poly-substance abuse. She listed his current medications as:

- Intuniv for ADHD.
- Trazodone(50mg) for sleep, one tablet at bed time.
- Abilify(10mg), mood stabilizer, for conduct disorder, 2 times daily.
- Depakener(250 mg),for behavior modification, liquid , 2 times daily.
- Clindamycin (solution), and Triamcinolone, for acnes, as needed.

Nurse Smoot indicated Youth A was prescribed Doxycycline (pill) medication up until April 10, 2012, that Youth A complained of stomach upset, and had refused the medication several times. She reported, sometimes, Youth A refused, specific meds, and sometime he refused all his meds. Per Nurse Smoot Youth A was dispensed all his medications, prescribed. She indicated Youth A was compliant with his medication, until he got mad, then he would stop for about a day, and then he would start again the next day.

Per Nurse, Smoot, Youth A medication refusal are documented on a medication refusal forms. Review of Medication Refusal forms showed thirty-four refusals, with twenty-two of them being for Doxycycline.

Youth A reported being on the following medications, and taking that medication either in the Am or Pm, Abilify (Am & Pm) Dapakote(Pm) and Intuniv( Pm). He indicated he refused his medications a few times, and that some days he refused all of them. He said there never was a time when he was not given his medications.

Review of Youth A's Medication Administration Records (MARS), showed staff's consistent dispensing and documentation of the Youth A's medication, no concerns were seen.

<b>APPLICABLE RULE</b>	
<b>R 400.4160</b>	<b>Health services, policies and procedures.Dispensing medication.</b>
	An institution shall establish and follow written health service policies and procedures addressing all of the following: (e) Dispensing medication.
<b>ANALYSIS:</b>	The evidence show that Youth A was dispensed his medications as prescribed my medical staff, missed or refused medications were documented.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

### **ALLEGATION:**

The Facility has roaches and bed bugs.

### **INVESTIGATION:**

The complainant indicated on July 3, 2012, per telephone contact, that Capstone has lots of bedbugs and roaches; and Youth A's mom see roaches, and kids are itching all the time.

The following individuals were interviewed related this allegation; Youth A, Youth A's Mother, Youth B, Administrative staff, Carita Brown, and Nurse, Patricia Smoot on July 5, 2012, Youth Specialists, Christopher Purnell, Orice Dennis, and Dewayne Fields on July 9, 2012; and Therapist Jamie Thomas, Youth C, Youth D, Youth E, Youth F and Youth G, as well as, Youth Specialist, Brandon Childs on July 10, 2012.

Youth A indicated roaches were everywhere in the building, and have been there during the four months he was placed at Capstone. He said he found a dead roach in his room a month ago; and two live roaches two weeks ago. He said "they have called the exterminator, but roaches are still here." He didn't know if other residents complained about roaches; and he was not aware of bed bugs. He said he did have bumps on his back, two months ago, which were treated with cream, and the nurse said it might be a spider bite.

Youth A's Mother reported seeing roaches or beetles in the Capstone basement, and that this is why Youth A has acne. She reported seeing roaches on several visitations, and then she said on two separate occasions, that she saw two live ones on the wall in March, and one dead one on the floor in June. When asked how many visits she had with Youth A, she said twelve; and when asked out of twelve visits, how many times she recalled seeing roaches, she said three. She said she never saw any bugs upstairs.

Of the six residents interviewed, other than Youth A, the results ranged from residents indicating they had not seen any roaches in their rooms, had seen a couple of live and dead roaches, to Youth E indicating the place is full of roaches, with them coming out of the vents. This youth also indicated Capstones sprays, but they still come back.

Youth B , Youth C and Youth F also reported being aware that Capstone sprays for bugs; and Youth E reported he may have been bitten by something in a heavy cover and mattress he had several months ago, that were replaced. Youth E and the other residents, who were interviewed, reported no problems with bedbugs. It is also noted that Youth B reported he once saw a mouse, but he did not report it to staff. This information about the mouse sighting was relayed to Mr. Ziglor at the time the matter was reported.

Of the seven staff interviewed, all reported being unaware of a problem in this area or children complaining of being bitten by bugs. A few staff indicated having seen a roach or two dead, or that a resident had reported seeing a few dead roaches. All indicated being aware of or hearing that Capstone terminates for roaches and bedbugs, though all had not witnessed such extermination. Ms. Brown indicated she had not personally seen a roach; and reported Capstone contracts with an extermination company to come out monthly to keep the building, which is damp, free from such pest. Per Ms. Brown, Utility Office Manager, Jatuana Beamer handles the extermination arrangements.

Per contact with Ms. Beamer on July 5, 2012, she reported Capstone has a monthly service with Gold Star Pest control, and the company was recently out to service the facility on May 26, 2012, and June 26, 2012. She too reported not having seen any bugs nor had residents complained to her about roaches or bugs. She said Gold Star sprays for “any bugs one can think of”, and does a three part spray with streaming if bugs are reported. Also that Gold Star will come out right away, if there is a sighting of pest.

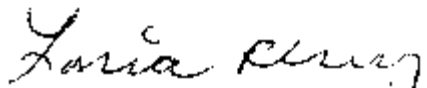
**Reviewed:**

- Statement from Gold Star Pest Control dated July 6, 2012 which indicated monthly services provided to Capstone since July 7, 2008; and to Capstone – North since May 21, 2012.
- Gold Star service slip invoice dated June 26, 2012 showing service that date for target pest, roaches and mice. It listed a last service date as January 24, 2012.
- Gold Star service slip invoice dated June 28, 2012 showing service that date for target pest, bedbugs. It listed a last service date as June 4, 2012.

<b>APPLICABLE RULE</b>	
<b>R 400.4407</b>	<b>Facility and premises maintenance.</b>
	(3) The facility, including main and accessory structures, shall be maintained so as to prevent and eliminate rodent and insect harborage.
<b>ANALYSIS:</b>	The evidence indicated a few roaches have been seen, but nothing major; and that the facility has a regular pest control system in place to combat concerns in this area.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.




October 14, 2012

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Lonia Perry  
Licensing Consultant

Date

Approved By:



October 17, 2012

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Linda Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

November 14, 2012

Sax Guthery  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2012C0420059  
Detroit Capstone

Dear Mr. Guthery:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
Suite 1000  
28 N. Saginaw  
Pontiac, MI 48342  
(248) 860-3317

Enclosure



**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2012C0420059
<b>Complaint Receipt Date:</b>	09/17/2012
<b>Investigation Initiation Date:</b>	09/17/2012
<b>Report Due Date:</b>	11/16/2012
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2011
<b>Expiration Date:</b>	03/21/2013
<b>Capacity:</b>	66
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Resident A was physically restrained. Resident A has bruises around his neck, which resident indicated were from staff choking him. After the altercation Resident A purposely hit his head on the wall in frustration and was taken to the hospital.

## III. METHODOLOGY

09/17/2012	Special Investigation Intake 2012C0420059
09/17/2012	Special Investigation Initiated - Telephone Phone to DHS Worker, also an email was sent to Clinical Director, P. Ziglor, in the PM
09/18/2012	Contact - Telephone call made Left Message for DHS Worker
09/19/2012	Contact - Face to Face Interviewed Resident A, spoke with Mr. Ziglor
09/20/2012	Contact - Telephone call made Spoke with DHS Worker
09/25/2012	Contact - Face to Face Interviewed Resident B, staff, A. Bell, F. Harris, and K Oldham
10/09/2012	Contact - Telephone call received Spoke with DHS Worker
10/09/2012	Contact - Document Received Photo
10/09/2012	Contact - Telephone call made Message left for staff, Michelin Dawson
10/10/2012	Contact - Face to Face Interviewed staff Michelin Dawson
10/12/2012	Contact - Telephone call made Spoke with DHS Worker
10/12/2012	Inspection Completed-BCAL Full Compliance

**ALLEGATION:**

Resident A was physically restrained. Resident A has bruises around his neck, which resident indicated were from staff choking him. After the altercation Resident A purposely hit his head on the wall in frustration and was taken to the hospital.

**INVESTIGATION:**

Resident A was interviewed on September 19, 2012, by this consultant. Resident B, Youth Specialists, Andre Bell, Fred Harris, and Kary Oldham were interviewed by this consultant and the Department of Human Services (DHS) Worker on September 25, 2012. Clinical Director, Pernel Ziglor, and Youth Specialist, Michelin Dawson were interviewed by this consultant on September 19, 2012, and October 10, 2012 respectively.

Resident A said Mr. Ziglor came to his door, and told him, his' and his roommate's pictures had to come down, as part of a consequence for negative behavior. He said he was irritated and speaking out against the consequence, when Mr. Oldham, Mr. Harris, and Mr. Dawson came into his room. He said the staff had heard a commotion and thought he or another resident was banging on the room door. He said as he was removing the pictures from the wall, Mr. Oldham kept getting in face/in his personal space, and taunting him. He admitted to getting smart with Mr. Oldham, yelling and telling Mr. Oldham to get out of his face, as well as, clinching his fist and jerking his face in front of Mr. Oldham. He said Mr. Oldham told him to stop trying to be tough, but Mr. Oldham also yelled and got smart with him. He admitted to cussing, telling Mr. Harris, who had told him to "chill out", to "shut the fuck up"; and said that when he told Mr. Harris the latter, Mr. Oldham said "I'm tired of this bullshit", grabbed him and starting restraining him.

Per Resident A Mr. Harris, Mr. Dawson, and maybe Mr. Montgomery or Mr. Bell assisted in the restraint. He indicated Mr. Oldham had his right arm, and Mr. Harris his left; he could not recall who had his legs. He said Mr. Dawson tried to calm him down; and during the restraint Mr. Oldham hurt his arm, by pulling it up toward his head. Also that Mr. Oldham, and Mr. Harris clinched the back of his neck, leaving a mark on his back and shoulder.

Resident A said he hit his head on the floor once during the restraint, in attempt to try to get staff off of him. He reported being restrained for about two to three minutes, and that after being released, he purposefully banged his head into a wall. He recalled being grabbed by staff and placed, in a "burrito"/ calming blanket, by Mr. Oldham, whom he state hurt his arm due to Mr. Oldham putting him in the "Burrito" the wrong way, by folding his arms up as opposed to across. Resident A stated he also blacked out and was seen by a nurse.

It is noted that a photo of Resident A's neck was viewed, and visible injuries were not noticeable.

Resident B reported before the restraint Mr. Oldham put his hand very close up in Resident's A face, and Resident A asked him to remove his hand. He indicated Mr. Oldham did not do as Resident A asked; and Resident A was getting mad, and balling up his fist. Resident B said he did not witness the restraint, that staff (whom he indicated were Mr. Oldham, Mr. Harris, Mr. Bell, Mr. Montgomery, and Mr. Dawson) asked him to step out of the room, but he could hear what was being said. He reported hearing Resident A screaming and saying "stop you're going to break my arm," and saying "am sorry, am sorry". He said Mr. Oldham responded "you should have been sorry before you did it." Per Resident B, Mr. Oldham was referring to Resident A kicking on the door.

Resident B said he heard the other staff tell Mr. Oldham Resident A was a kid, and to watch what he was doing.

Mr. Bell reported Resident A was verbally threatening, and flinching at Mr. Oldham; and Mr. Oldham grabbed for Resident A and a two man take down occurred. He said thereon Mr. Oldham was on one arm, Mr. Harris the other and Mr. Montgomery was on the legs. He said there was nothing unusual about the restraint, and the only person cussing was Resident A. He did not hear Resident A saying his arm hurt, but indicated it may have, because restraints are not comfortable; and despite staff's efforts to try to calm Resident A, Resident A, who was on his back, kept trying to get out of the restraint.

Mr. Ziglor, Mr. Harris and Mr. Dawson reported they did not observe the restraint.

Mr. Ziglor acknowledged ordering the consequence, due to Resident A and or Resident B banging behavior; and that he told Mr. Oldham the pictures on the boys' wall must come down. He never saw, Mr. Oldham, Mr. Harris, or other staff go into Resident A, and Resident B's room.

Mr. Harris reported intervening with Resident A earlier, related to the residents' horse playing. He said he was in the doorway, but he denied being involved in the restraint or witnessing it. He did not recall who was in Resident A's room; but said Mr. Oldham, as the team leader would have been around, if there was a restraint. He said he (Mr. Harris) excused himself after Resident A said "F" you Mr. Harris".

Mr. Dawson reported he attempted to deescalate Resident A; and what he saw was other staff trying to calm Resident A down. He said Resident A was cussing and being verbally aggressive with Mr. Oldham and Mr. Harris. He said he did not see Mr. Oldham make physical contact with Resident A; and he did not know what staff were involved in the restraint.

Mr. Dawson reported seeing Resident A during the nurse's assessment; and that Resident A was "red in the face from being worked up" but he did not notice any marks or bruises to the resident's neck. He said the resident was upset and crying,

then just yelled and hit his head on the wall. He said the resident was taken to the hospital.

Mr. Oldham reported Resident A was banging on his door, would not listen to redirection, “balled his hands up, and flinched as if he was going to jump me”. He said he grabbed Resident A’s wrist, and he and Mr. Bell restrained Resident A. Mr. Oldham indicated he had one arm and Mr. Bell had the other. He did not recall any staff having Resident A’s legs. He was not sure what other staff was present in the room, but said Mr. Montgomery and Mr. Harris may have been, or Mr. Harris may have in the door. He did not recall Mr. Dawson being present. He said Resident A was cussing and being verbally disrespectful, and they were asking him to calm down. He denied cussing Resident A, putting his hand in Resident’s A face, or hurting Resident A’s arm. He indicated “oh no” that there was never a time his hand or another staff’s hand was put on Resident’s A neck.

Mr. Oldham reported the restraint lasted about five minutes, that Resident A was aggressive and fighting the restraint. Mr. Oldham did not notice any marks or bruises to Resident A’s body after the restraint.

Reviewed:


- Incident report, dated 9/14/12, which indicated Resident A was kicking and banging on his door, was physically aggressive toward staff, and banged his head on the wall.
- Nursing notation which indicated red bruises to the resident’s shoulders, and chest. Blood in Resident A’s hair after he banged his head on the wall.
- Children’s Hospital Emergency Discharge instructions dated 9/14/12, that indicated the resident had a head injury; and noted observation and discharge instructions.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (i) Excessive chemical, mechanical, or physical restraint.

<b>ANALYSIS:</b>	<p>Although there is some question as to whether staff, Mr. Oldham taunted Resident A, the resident did become verbally and physically aggressive, was restrained, and fought against the restraint.</p> <p>Additionally, noting some inconsistency related to who assisted Mr. Oldham in the restraint, the staff who acknowledged witnessing/ being involved in the restraint, reported it as a normal restraint, without noticeable incident to the resident.</p> <p>The evidence does not support excessive physical restraint.</p>
<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.



November 14, 2012

Lonia Perry  
Licensing Consultant

Date

Approved By:



November 15, 2012

Linda Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

November 28, 2012

Sax Guthery  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2013C0420002  
Detroit Capstone

Dear Mr. Guthery:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
Suite 1000  
28 N. Saginaw  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2013C0420002
<b>Complaint Receipt Date:</b>	10/01/2012
<b>Investigation Initiation Date:</b>	10/01/2012
<b>Report Due Date:</b>	11/30/2012
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 28511 Orchard Lake Rd Farmington Hills, MI 48334
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2011
<b>Expiration Date:</b>	03/21/2013
<b>Capacity:</b>	66
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE



## II. ALLEGATION(S)

Youth 1 alleged that sometime in February 2012, Youth 2 tried to have sex with him.

## III. METHODOLOGY

10/01/2012	Special Investigation Intake 2013C0420002
10/01/2012	Special Investigation Initiated - Face to Face Met DHS worker on site.
10/01/2012	Contact - Face to Face Spoke with Clinical Director, Pernell Ziglor, interviewed Youth 1 and Youth 2
10/03/2012	Contact - Telephone call received Spoke with DHS Worker
10/19/2012	Contact - Telephone call made Spoke with DHS Worker
10/19/2012	Inspection Completed-BCAL Full Compliance
10/19/2012	Comment- Exit

### ALLEGATION:

Youth 1 alleged that sometime in February 2012, Youth 2 tried to have sex with him.

### INVESTIGATION:

Clinical Director, Pernell Ziglor, Youth 1 and Youth 2 were all interviewed by this consultant and the DHS Worker on October 1, 2012.

Per Mr. Ziglor this complaint surfaced after the police interviewed Youth 1 related to another sexual interaction issue involving two other prior Capstone youths. He indicated the police officer requested to also interview Youth 2, because Youth 1 alleged a sexual interaction with Youth 2. Mr. Ziglor indicated the alleged incident between Youth 1 and Youth 2 was reported to have occurred sometime prior to the incident involved the other two youths; and prior to Youth 1's returned to Capstone in June, 2012.

Mr. Ziglor indicated Youth 1 and Youth 2 had shared a room up until March; and there appeared to be some sexual issues for each youth, but nothing of a perpetrator nature. He indicated neither youth had been designated a sexual offender status. He indicated the youths were separated; and that per the prior Director, Ms. Gerber-Somers the matter was indicated to licensing, and the matter was determined to be a therapeutic issue.

Youth 1 indicated there was nothing to talk about related to Youth 2, and that he was focused on the outcome of the matter with Youth 3 (one of the two youths referred to earlier, and so named for this report). Youth 1 said the incident occurred around February 2012, and that Youth 2 “tried to rape me”. Youth 1 refused to be interviewed in detail, or to state what actually happened. However, he did indicate he and Youth 2 shared a room, whereby it was just the two of them in the room, the incident happened once, in their room, and it occurred at night around five or six o’clock pm.

Youth 2 acknowledged having shared a room with Youth 1, but denied forcing or trying to force Youth 2 into a sexual activity. He said there was no sexual contact between him and Youth 1; that they wrestled and engaged in horseplay, but they were both clothed when they were playing. He indicated as far as he recalled Youth 1 made a sexual allegation against him one morning during group therapy. He said Youth 1 wanted to do a “GT” group talk, but the staff indicated they could not do a group on that issue, but Youth 1 still brought it up. Youth 2 indicated thereafter he addressed the issue with his therapist, Ms. Thomas; and Youth 1 would have talked with his therapist.

Youth 2 also indicated that “once on the court yard”, Youth 1 said “you statutory raped me, you molested me”. Youth 2 reported not knowing why Youth 1 alleged those things against him. He said that prior to this allegation they had a good relationship; that Youth 1 reported in “GT” talk that his (Youth 1) uncle did some sexual things to him; but he said he (Youth 2) never did.

Reviewed:

Incident reported dated 2/10/12, which indicated various different accounting from Youth 1 as to what occurred with Youth 2; that:

- During individual session on 2/6/12, Youth 1 reported to Ms. Thomas that his peer, referring to Youth 2, tried to solicit oral sex from him on Friday, 2/3/12, and he informed the supervisor on Sunday 2/5/12. That the supervisor, Mr. Sam moved Youth 2.
- Ms. Thomas spoke with Youth 1 again for clarity, and Youth 1 said the peer exposed himself on Saturday 2/4/12, and asked him (Youth 1) to “suck it”. Additionally, that Youth 1 later indicated that on Saturday the peer grabbed his arm and let him go, but his peer was not exposed.
- On 2/8/12 Youth 1 informed Ms. Thomas and the CMO worker, the peer held him up against the wall on Saturday.
- On 2/9/12 that Ms. Thomas was informed by Mr. Ziglor who had spoken with Youth 1 that Youth 1 reported that the peer “only grabbed his arm” and that nothing happened.
- On 2/10/12 Youth 1 reported to Ms. Gerber-Somers (prior Capstone Director) that the peer “pinned him down”, but he was not exposed.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(2) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS:</b>	<p>Youth 1 refused to give any details as to what occurred, Youth 2 denied any sexual activity with Youth1, and Youth1 gave varying past accountings as to what occurred, ranging from an attempted molestation by Youth 2, to nothing happening.</p> <p>Additionally, when Youth 1 made his initial allegation in February, Youth 1 and Youth 2 were separated from sharing a bedroom.</p> <p>The evidence does not support a lack of protection or direct care and supervision.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.




November 27, 2012

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



November 28, 2012

\_\_\_\_\_  
Linda Tansil  
Area Manager

\_\_\_\_\_  
Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

December 4, 2012

Sax Guthery  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2013C0420003  
Detroit Capstone

Dear Mr. Guthery:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
Suite 1000  
28 N. Saginaw  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2013C0420003
<b>Complaint Receipt Date:</b>	10/03/2012
<b>Investigation Initiation Date:</b>	
<b>Report Due Date:</b>	12/02/2012
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 28511 Orchard Lake Rd Farmington Hills, MI 48334
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2011
<b>Expiration Date:</b>	03/21/2013
<b>Capacity:</b>	66
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Resident 1 reported he engaged in sexual inappropriate behavior with several past and current Capstone residents.

## III. METHODOLOGY

10/03/2012	Special Investigation Intake 2013C0420003
10/09/2012	Contact - Telephone call made Spoke with DHS Worker
10/09/2012	Contact - Document Received Children serve green alert, photo of Resident 1
10/10/2012	Contact - Face to Face Spoke with Clinical Director, P. Ziglor, interviewed Resident 1
10/10/2012	Contact - Document Received Incident report, resident statement
10/12/2012	Contact - Telephone call made Spoke with DHS Worker, she will follow up on discharged Resident 2
10/18/2012	Contact - Telephone call received Message from DHS Worker
10/19/2012	Contact - Telephone call made Spoke with DHS Worker, she had unsuccessful efforts related to contacting Resident 2, closing case
10/19/2012	Inspection Completed-BCAL Full Compliance

### ALLEGATION:

Resident 1 reported he engaged in sexual inappropriate behavior with several past and current Capstone residents

### INVESTIGATION:

Resident 1 indicated there were four residents named, but he said he only engaged in sexual activity with two of the residents, who shall henceforth be referred to as Resident 2, Resident 3, Resident 4, and Resident 5. It is noteworthy that with the exception of Resident 5, the other three residents are no longer placed at Capstone.

Resident 1 reported that nothing happened with Resident 3; and that he only engaged in horseplay with Resident 4.

Resident 1 said he and Resident 2 shared a room together about four to five months ago, and one night between 9:30pm and 10:00pm he and Resident 2 "jacked each other off". He said Resident 2 asked him to jack him (Resident 2) off, and gave him a glove to use. Resident 1 said he really did not want to do it, but "I was curious".

Resident 1 could not recall what staff was on duty the night of the incident with Resident 2, and indicated staff was doing rounds back and forth and checking the rooms by opening the door. He said it was dark, staff could not see, and he and Resident 2 went behind the back wall.

Resident 1 reported the incident with Resident 5 happened about three months ago, in the observation room, which he shared with Resident 5 and one other resident. He said he believed staff, Mr. Parnell was the 1:1 staff person for Resident 5, and that staff sat on their door, which was opened. He said the other resident was talking to the staff, and that either that resident or the staff knew what he and Resident 5 were doing. He said Resident 5 asked if he wanted to feel his private part, he agreed and touched Resident 5's private part, and Resident 5 touched him.

Resident 1 said there was nothing staff could have done in either incident, because the staff did not know, he and the other resident went out of camera view, and he never told anyone. He said neither Resident 2, nor Resident 5 threaten him, that Resident 5 asked him not to tell, and he agreed, then Resident 5 spread rumors that he (Resident 1) was Bisexual. He indicated he was disclosing this information now because he wants his "life to be more truthful". Additionally, that his parents have encouraged him to do whatever he must do to assist himself with his program completion.

Clinical Director, Pernell Ziglor reported Resident 1 was never placed in the observation room with Resident 5, whom Resident 1 alleged to have engaged in sexual activity with. Mr. Ziglor indicated Resident 5 had shared the observation with another youth, whereby Resident 5, had alleged inappropriate interaction by that residents; and that Resident 1 may have heard about that situation, Mr. Ziglor was not aware of any sexual interaction allegations related to Resident 1 and the other indicated residents, until this complaint. He indicated Resident 3 is a transgender youth, and Resident 3 was never placed in a room with Resident 1, or other residents.

Mr. Ziglor indicated that from a therapeutic perspective, Resident 1 has a tendency to mix his sexual fantasies with reality, and Resident 1 has fluctuated between the two realms, which may cause him to have distorted perceptions of what occurred or did not occur.

Per telephone contact with the Department of Human Service (DHS) Worker, Resident 1's mother reported Resident 1 has a history of mental health issues; and when he goes into a psychotic mode, he get very sexual.

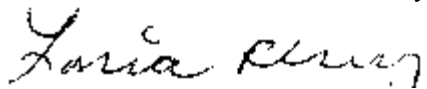
Reviewed:

- Incident report
- Resident 1 statement

APPLICABLE RULE	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(2) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS:</b>	Resident 1 could not recall what staff may have worked when the incident with Resident 2 occurred, and he was not certain related the staff he named as present when the incident with Resident 5 occurred. He indicated staff were making their required rounds/room checks, there was nothing staff could have done; and he and the other resident avoided the camera and ensured they were not caught.  The evidence does not support a lack of supervision.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**RECOMMENDATION:**

Continuation of the facility's current licensing status is recommended.



**November 29, 2012**

Lonita Perry  
Licensing Consultant

Date

Approved By:



**December 4, 2012**

Linda Tansil  
Area Manager

Date





RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

May 24, 2013

Sax Guthery  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2013C0420026  
Detroit Capstone

Dear Mr. Guthery:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

**FOR CWL ONLY**

Please note that violations of any licensing rules are also violations of the MSA and your contract.

Sincerely,

Lonie Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2013C0420026
<b>Complaint Receipt Date:</b>	03/28/2013
<b>Investigation Initiation Date:</b>	03/29/2013
<b>Report Due Date:</b>	05/27/2013
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Resident A was restrained on 3/7/13, and afterward had injury to his upper lip; and it was later alleged the resident had a swollen head, eye , and injury to his tooth, lower lip and arm.

## III. METHODOLOGY

03/28/2013	Special Investigation Intake 2013C0420026
03/29/2013	Special Investigation Initiated - Telephone Spoke with DHS Worker
03/29/2013	Contact - Document Sent Email to Director
03/29/2013	Inspection Completed On-site Interviewed staff and Resident A
03/29/2013	Contact - Document Received
04/08/2013	Comment- Exit discussed with agency
04/24/2013	Contact –Document received Email from DHS Worker
04/24/2013	Special Investigation Completed- BCAL Full Compliance

### ALLEGATION:

Resident A was restrained on 3/7/13, and afterward had injury to his upper lip; and it was later alleged the resident had a swollen head, eye , and injury to his tooth, lower lip and arm.

### INVESTIGATION:

Resident A, and Youth Specialists, Michelin Dawson, was interviewed on March 29, 2013, by the DHS Worker and this Consultant. Youth Specialists, Nicholas Hayes, and Terrell Montgomery, as well as, Supervisor, Marlon Williams were also interviewed by this Consultant on March 29, 2013.

Resident A reported being placed at Capstone on March 22, 2013. He said he was doing alright until he was restrained for no reason. He said he was told to leave the lunch room after he was about to fight another resident. He said he was escorted to his room, his arms were folded in front of him, but staff said they were not folded correctly; and when he got to his room all his stuff was taken out. He said he was upset; he balled up his fist at first, but un-balled them. That after his door was closed he got mad, and began to exercise, to calm down.

Resident A said “they got mad at me because I was throwing out gang signs, and that staff was pacing back and forth at his door. He said Mr. Williams opened his door and was “letting him talk junk’ that he told staff he “ will fight any one of them one on one”. He indicated when he was talking junk, Mr. Dawson dared him to ball up his fist, Mr. Hayes was on his (Resident A) right side talking to him, and Mr. Hayes called him a “Bitch” He denied cussing staff, other than to say that he would fight or beat any of their “asses”. He denied his fists were balled while staff talked to him. He said Mr. Dawson, Mr. Montgomery and Mr. Hayes restrained. That Mr. Hayes grabbed his right arm, Mr. Dawson his left, and Mr. Montgomery had his legs. He said they slammed him to the floor and his face hit the floor and he bit his lip. He said blood was on the floor, but not a lot of blood. It is noteworthy that Resident A had a red blot mark inside his right eye, and a nearly healed mark to his lip. He denied fighting the restraint, and said Mr. Hayes put lots of pressure on his arm, and they were injured due to the restraint. He said the restraint lasted about two minutes, Mr. Williams told them to release him, and they did. He saw the nurse afterwards. He said when he got up his head, arm, lip and eye hurt, that the nurse gave him Motrin.

Mr. Michelin, Mr. Hayes, Mr. Montgomery, and Mr. Williams denied Resident A was slammed to the floor, and indicated the youth either felt or dropped to the floor. They also denied that any staff cussed or taunted the youth. Each indicated the youth attempted to assault staff and was physically managed; and that Mr. Williams instructed staff to release the youth from the restraint, after a couple of minutes. Each reported Resident A had been escorted from the lunch/dining room to his room, due to his negative behavior and refusal to follow staff directives.

Mr. Michelin reported after Resident A was placed in his room, Resident A was upset and was being loud and verbally threatening to staff. He said Resident A said “I’ll knock one of you motherfuckers out “ , if one of them entered his room. He said they attempted to de-escalate the youth from outside the youth’s door; and the situation went on for ten to fifteen minute prior to them entering the youth’s room. When he and Mr. Hayes entered the room, Resident A, had his back up against the wall, his fists balled and told Mr. Dawson and Mr. Hayes he would fight them one on one. He said Resident A swung on him; he attempted to grab the youth’s arm, missed, and the youth dropped to the floor. He and Mr. Hayes then secured Resident A, he grabbed the youth’s left arm and Mr. Hayes the right. He indicated the youth was on the ground, and he and Mr. Hayes were on one knee, in a ‘fireman’s stances” holding the youth. He said the youth’s face was facing the ground; that when the youth went to the floor, the youth’s knee and hand hit the ground and he caught himself and extended his arm.

Mr. Michelin said Resident A was upset and crying; the supervisor, Mr. Williams arrived and instructed them to release the youth and they did. He said the whole incident last about three minutes; and the youth was still crying and upset when the Nurse and Mr. Ziglor arrived.

Mr. Hayes reported he was called to intervene with the youth when the youth refused to follow staff directive in the lunch room. He escorted the youth to his room. After the youth was placed in his room, Mr. Hayes said he noticed Resident A was still upset, was moving side to side with fists balled, "like he was getting rest to fight". He said the youth was not exercising; that the youth had his shirt off, with his hands on both ends of his shirt, and he (Mr. Hayes) got concerned the youth might put the shirt around his head. He said he and Mr. Dawson entered the youth's room. They instructed Resident A to put the shirt down; and he, Mr. Dawson and Mr. Montgomery tried to de-escalate the youth, but the youth was being verbally and physically aggressive. That the youth threw the shirt at Mr. Dawson, threaten that "if anyone touches me I'm gonna blow their shit out". He indicated Resident A lunged at, and swung on Mr. Dawson, who then tried to physically manage the youth with a blind side swoop. He indicated that either from the momentum of Resident A's punch or Resident A somehow tripping, Resident A fell to the ground. At which time he and Mr. Dawson each grabbed one of Resident A's arms and placed them behind the youth's back. Mr. Hayes did not report anyone having the youth's legs. He said when the youth fell to the floor, the youth was on his chest and he assumed the youth's face may have hit the ground, but he did not see it. He said Mr. Williams came after the youth threw the shirt; that everything happened quickly, the restraint lasted only a couple of minutes.

Mr. Montgomery denied being a part of Resident A's restraint, but indicated he assisted in the room escort, the removal of items from the youth's room; and the efforts to de-escalate the youth. He said staff Mr. Bell was not involved at all. He said Resident A was verbally aggressive to Mr. Dawson and Mr. Hayes; and that staff were calm and trying to get the youth to unclench his fist. He said the youth threaten to hit who so ever walked up on him; and at that time, he, Mr. Dawson and Mr. Hayes were in the youth's room trying to de-escalate the youth. He said Resident A was in the center of the room, facing Mr. Dawson and Mr. Hayes, who were on opposite sides of the youth. He was positioned near the door and "could see all". He said Resident A focused his attention on Mr. Dawson. He said the youth stepped toward Mr. Dawson with fist balled, lunged at Mr. Dawson; and Mr. Dawson tried to grab the youth's arm, to conduct a blind side swoop, but Resident A fell down. He said the youth could not catch himself; and the youth landed on the floor and ended up on his chest. Mr. Montgomery could not recall if the youth's head or eye hit the floor; but indicated the youth was lying face down, so there was a possibility he could have hit himself on the floor. He said Mr. Dawson and Mr. Hayes subdued the youth, each had an arm; and no one had the youth's legs.

Mr. Williams indicated when he arrived on the scene, Resident A was on the wall with his fists balled; staff Mr. Hayes and Mr. Dawson were on each side of the youth trying to talk with him. He said he was told Resident A had thrown his shirt, but he did not witness that. He said the youth lunged at Mr. Dawson, Mr. Dawson moved back, grabbed for the youth's arm and Mr. Hayes grabbed the other. He said Resident A dropped to the floor, to both his knees, was refusing the restraint, trying to get his arms loose, then the youth went down to the floor, and was on his chest.

Mr. Williams indicated as the youth was going to the floor, the youth was cussing and threatening to “fuck all of you up”. Mr. Williams said soon after Resident A was on the floor, the youth said “I’m cool, I’m not going to mess any one up”, and he instructed the youth to remain calm, and advised the staff to release the youth.

When asked if Resident A complained about his arms hurting or whether the youth had any marks or bruises after the incident, the respective staff reported the following:

Mr. Michelin said after they released Resident A, the youth complained his arms hurt. He did not notice a mark, bruise or injury to Resident A’s eye; but observed a bruise to the youth’s lip. Mr. Michelin said the inside of the youth’s upper lip was red.

Mr. Hayes said the youth was crying, but never complained that his arms were hurting. He indicated afterward, the nurse said Resident A said his arms hurt, but he question that. He said the youth had done a push up to get himself off the floor. He said it looked as if Resident A had a mark on the inside of his upper lip, but Mr. Hayes denied seeing blood. He did not observe an injury to the youth’s eye, during or after the restraint. He acknowledged the youth now has a red clot to his eye.

Mr. Montgomery said during the restraint Resident A said his arm hurt; that it looked as if the youth upper lip was hurt “that he bit it”. He said before the restraint Resident A was “snorting” showing his teeth and biting at the corner of his mouth.

Mr. Williams reported Resident A never said his arm was hurting, that the youth said “they got my arms man; tell them to let me go”. Mr. Williams never noticed any marks or bruises to the youth.

Reviewed:

- Incident report indicating verbal aggression by Resident A, and him becoming physical aggressive toward staff when they entered his room to de-escalate him; and thereon him being physically managed.
- A nurse note, from Nurse, Keith Miller dated 3/27/13, that indicated a body audit revealed no bruises or swelling. Resident complained of pain in bilateral arms and refused to rate his pain. The “resident’s upper lip inside mouth, skin is broken, no bleeding noted. Resident is able to perform ROM with all four extremities, PRN given for c/o pain, and first aid was rendered to upper lip.”
- Written Witness statements from, Mr. Montgomery, Mr. Dawson and Mr. Williams.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following:

	(i) Excessive chemical, mechanical, or physical restraint.
<b>ANALYSIS:</b>	The evidence does not support cruel and severe discipline. Resident A was verbally and physically aggressive toward staff and was restrained. During the staff's attempt to physically manage Resident A, he fell to the floor and may have bit his lip and hit his head. His arms may have also experienced discomfort from the restraint.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing is recommended.

*Lonia Perry*

May 23, 2013

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:

*Linda D. Tansil*

May 24, 2013

\_\_\_\_\_  
Linda Tansil  
Area Manager

\_\_\_\_\_  
Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

May 28, 2013

Sax Guthery  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2013C0420028  
Detroit Capstone

Dear Mr. Guthery:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonja Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure



**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2013C0420028
<b>Complaint Receipt Date:</b>	04/02/2013
<b>Investigation Initiation Date:</b>	04/03/2013
<b>Report Due Date:</b>	06/01/2013
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Resident A alleged that during a physical restraint staff, Mr. Hayes grabbed her head and banged it to the floor.

## III. METHODOLOGY

04/02/2013	Special Investigation Intake 2013C0420028
04/03/2013	Special Investigation Initiated - Letter Email to DHS Worker
04/04/2013	Contact - Document Received Email from DHS Worker -scheduling
04/08/2013	Contact - Face to Face Interviewed, Youth A, staff, Nicholas Hayes, and Kary Oldham and Youth B and Youth C
04/25/2013	Comment- Exit
05/02/2013	Inspection Completed- BCAL Full Compliance

### ALLEGATION:

Resident A alleged that during a physical restraint staff, Mr. Hayes grabbed her head and banged it to the floor.

### INVESTIGATION:

On April 8, 2013, Resident A, Resident B, Resident C; and Youth Specialists, Nicholas Hayes, and Kary Oldham were interviewed by the Department of Human Services Worker, and this Consultant.

Resident A reported staff thought she had a sexual relationship with her past roommate; and that during shower time, Mr. Tucker and Mr. Oldham informed her that her room was being changed. She became upset, "I was mad" did not want to be moved, and she refused to go. She went to look for socks in the hygiene cart and was pulling hygiene boxes off and was trying to walk back into the all-purpose room, and Mr. Tucker blocked her entry. Mr. Oldham, who was already on the floor, and Mr. Hayes, who arrived on the scene, told her to go to her room. Mr. Oldham yelled and told her she was going; that "Aint nobody about to be going back and forth with your ass. Either you gonna walk are we gonna put her ass in there ourselves." She said Mr. Hayes grabbed the hygiene cart and said "Oh so it's like that, that's how it is"; and he grabbed her right arm, and twisted it to behind her back. She told him to get off her, and then Mr. Oldham grabbed her other arm, and the two staff escorted her to her room. She indicated during the escort she was trying to "snatch" her arms loose "because it was hurting".

Resident A indicated Mr. Oldham and Mr. Hayes pushed her into her room, and she almost fell. She said she then turned around got in Mr. Oldham's face, told him he

had no right to touch her; she was not being aggressive to herself or others. She said she pushed Mr. Oldham and he grabbed her clothing and began pushing her into the wall. Then he instructed Mr. Hayes to grab her, and Mr. Hayes grabbed her by the right side of her neck with one of his hands and took her to the floor. She said she fell “sideways, on her left side, and Mr. Hayes fell on top of her on her right side. She said Mr. Hayes “hand was still on my neck” and “as I was trying to move my head off the floor” Mr. Hayes pushed her head back down hard, and she busted her lip. She said she hit her lip on the floor, it bleed, and was swollen. She indicated when she told Mr. Hayes and Mr. Oldham about her lip bleeding; Mr. Oldham said “don’t nobody care about your lip bleeding”. She said Mr. Hayes said “that can get fixed”, and he was still on top of her, and he laid there for about ten minutes; and when she was calm, Mr. Hayes and Mr. Oldham were still there.

Resident B indicated no other staff witnessed the incident that her room door was open, and Resident C heard what was going on from her (Resident C) room next door. She said she saw Resident B was in the doorway watching from the room across from her room. After the incident, Resident A said she saw the nurse. She received an ice pack, and cream for the inside of her mouth/her lip to “help with the bleeding” .

Nicholas Hayes and Kary Oldham each denied Mr. Hayes pushed Resident A’s head to the floor; and denied the allegations as reported by Resident A. Each indicated Resident A refused to move to her room, she was escorted by the two of them; and she was physically managed in her room, due to her physical aggression to staff.

Mr. Hayes reported he and Mr. Oldham attempted to de-escalate to Resident A’s behavior, that he told her it was not that serious, just a room change. He said Resident A stood up in front of a chair without permission, and proceeded to grab the plastic hygiene cart, she threw the cart behind her, in the direction of Mr. Hayes and Mr. Oldham who were on each side of her. He said they then escorted Resident A to her room using a two-man escort whereby the resident’s arms were behind her back. Mr. Hayes indicated once they arrived at Resident A’s room, they stopped to allow Resident A to walk into her room, she turned around, swung and struck him in the chest with a closed fist; and she was physically managed.

Mr. Hayes said he performed a blindside swoop, which entailed grabbing both of the resident’s arms. Then he took her to the “Sitter” position which meant she was sitting on her butt; and he still had her arms. He said she was physically managed for two to three minutes; and Mr. Oldham had control of the resident’s leg to prevent her movement.

Mr. Hayes denied touching Resident A’s neck, that there was ever a time that the youth was on her side while she was on the floor, or that he was on top of her. He said Resident A was sitting on her butt, there was no chance her head hit the floor;

and he never had his hand on her neck. He indicated Resident A was the person cussing, making statements such as “I am not moving my Fucking room”, that he and Mr. Oldham never used profanity; they were just trying to calm her down. He said Resident A never said her lip was busted or bleeding; and he did not observe any bruises to the resident’s body or lip at the time. He acknowledged learning later, from the nurse’s note, that the youth’s lip was swollen.

Mr. Oldham reported Resident A was upset and he assisted Mr. Hayes in escorting her to her room. He said before they grabbed her she has taken a hygiene crate and thrown it, but she did not throw it at anyone in particular. Mr. Oldham indicated once he and Mr. Hayes arrived at the resident’s room, her door was opened, and they let her go. He said Resident A walked into the room, turned around with fist or fists balled and swung wildly on him and Mr. Hayes. He said Resident A was cussing, and indicated “Yall don’t fucking know me”; and at least two of her punches landed in his stomach, and Mr. Hayes got more than two punches in his chest area.

Mr. Oldham indicated due to the physical assault, he and Mr. Hayes had to go into the resident’s room. He said he tried to grab Resident A’s wrists, but he could only get one, and Mr. Hayes did a blindside swoop, and placed Resident A in the “Sitter position. He said he never touched Resident A’s legs, that once she was in the” Sitter” position,” there was no reason to touch her, because Hayes had her”. He said the youth never was on her side, Mr. Hayes never fell on top of her; and her head never hit the ground.

Mr. Oldham indicated once Mr. Hayes had Resident A in the restraint, she apologized and blamed her behavior on problems she was going through. He said the restraint last about three minutes. He did not observe any injuries to Resident A during or after the restraint; and she never said she was injured, bleeding, or complained of pain. He acknowledged that when she saw the youth the next day her lip was swollen a little.

Resident B recalled the incident. She said she and Resident C were standing in the hall by her door, and she and Resident C saw what happened. Resident B said Resident A was in the hall, and Mr. Oldham and Mr. Hayes told Resident A to go to her room and Resident A told both staff not to touch her. Resident B indicated Resident A was taken to her room, and then Resident A was facing Mr. Oldham and she pushed Mr. Oldham “off like” to say “don’t touch me”. Resident B said then Mr. Oldham and Mr. Hayes was in Resident A’s room; and Resident A pushed Mr. Hayes, that Mr. Hayes was in Resident A’s person space. She said Mr. Hayes and Mr. Oldham took Resident A to the floor, that each staff took one of Resident A’s arms. Resident B said when the two staff took Resident A to the floor, Resident A’s lip hit the bed, Resident A fell to the floor; and said “Hayes you busted my lip”. Resident B said Mr. Hayes responded by saying “You never should have assaulted staff.”

Resident B indicated once Resident A was on the floor, Resident A was calm; not trying to fight the restraint, and Resident A was on her stomach. She said no staff had Resident A's legs, just her arms. Resident B said Resident A was released when she calmed down, and afterward Resident A's walked to the door and said "them mother fuckers busted by lip". Resident B said the inside of Resident A's lip was bleeding a little; and when she saw Resident A, the next day, Resident A's lip was swollen.

Resident C indicated she saw Mr. Hayes and Mr. Oldham walk Resident A to her room; but she did not see what happened in the room. She said she heard the incident. She said one staff, after some guessing, on her part, she identified as Mr. Oldham's voice, said, "You want to hit me, this is what you get". She said she heard Resident A scream, and she heard a boom, which she assumed was when Resident A was restrained.

Resident C denied being in the hallway or seeing another resident in the hallway by Resident A's door. When asked specifically if she saw Resident B in the hallway near Resident A's door, she could not recall.

Reviewed;

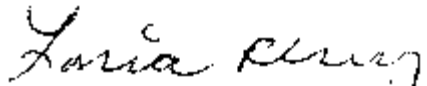
- Incident report that indicated Resident A was upset over her room change, she threw an underwear crate behind her; and she was escorted to her room. That she then assaulted staff and was restrained.
- A written statement from Resident A indicating while Mr. Hayes and Mr. Oldham restrained her, Mr. Hayes grabbed her head and banged it to the floor; and now her lip was swollen, and "I need somebody to do something about it."
- An unidentified written statement from a reported resident, that indicated a resident named Resident A "got restrained, and her lip got busted and it swollen. I would like if the situation get looked into."
- A nurse's follow-up note, on the incident report, by Nurse Miller, that indicated Resident A's "upper lip swollen, appears to have been punctured by bottom tooth, left has a scratch, c/o bilateral shoulder pain. " X-ray was ordered and first aid rendered.

APPLICABLE RULE	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (i) Excessive chemical, mechanical, or physical restraint.

<b>ANALYSIS:</b>	<p>The evidence does not support cruel and severe discipline.</p> <p>The two staff involved in the incident denied the allegations as reported by Resident A; and although it is noted the two staff reported different statements related to whether a staff held Resident A legs, Resident A's and the two other residents/ reported witnesses' account of the incident were also varied .</p> <p>Additionally, the nursing assessment indicated Resident A's lip injury appeared to have been due to a puncture from her bottom tooth.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.



May 27, 2013

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



May 28, 2013

\_\_\_\_\_  
Linda Tansil  
Area Manager

\_\_\_\_\_  
Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

June 25, 2013

Sax Guthery  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2013C0420031  
Detroit Capstone

Dear Mr. Guthery:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2013C0420031
<b>Complaint Receipt Date:</b>	04/20/2013
<b>Investigation Initiation Date:</b>	04/22/2013
<b>Report Due Date:</b>	06/19/2013
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE



## II. ALLEGATION(S)

Improper Restraint, Resident A was restrained by staff Mr. Tucker during the midnight shift, and has two long scratches on his shoulder.

## III. METHODOLOGY

04/20/2013	Special Investigation Intake 2013C0420031
04/22/2013	Special Investigation Initiated - Letter Email to DHS Worker
04/24/2013	Contact - Document Sent Email to and facility Director, Guthery
04/24/2013	Contact - Document Received Statement
04/24/2013	Contact - Face to Face Attempted interviews with Resident A, Resident B and Resident C
05/02/2013	Contact - Face to Face Interviewed staff, attempt interview with Resident D
05/21/2013	Contact - Telephone call made Spoke with Youth Specialist , Alicia Wilson
05/21/2013	Contact - Telephone call made Spoke with Youth Specialist , Byron Tucker
05/21/2013	Contact - Telephone call made Spoke with DHS Worker
05/22/2013	Special Investigation Completed-Full Compliance
06/11/2013	Comment- Exit

### ALLEGATION:

Improper Restraint, Resident A was restrained by staff Mr. Tucker during the midnight shift, and has two long scratches on his shoulder.

### INVESTIGATION:

Interviews were attempted with Resident A, Resident B, and Resident C on April 24, 2013; and the resident either refused to be interviewed or to speak in detail as to what if anything the resident saw or heard related to the allegation.

Resident A refused to answer this Consultant's questions. He stated "I'm good" got up from the interview table and asked to be taken back to his room.

On May 2, 2013, this Consultant was present during the DHS Worker's interview with Resident A, at which time, Resident A indicated there was "nothing to talk about" that he had "nothing to say".

Resident B initially denied any knowledge of the incident; and after this Consultant informed him he was observed, on video, going into Resident A's room during the time of the incident, Resident B indicated Mr. Tucker and Resident A "weren't doing anything but talking". He indicated Mr. Tucker and Resident A were talking face-to-face; and "no one was swinging or punching anyone". He indicated "that all I remember and I don't have any more to say".

On May 2, 2013 when interviewed by the DHS Worker, in this Consultant's presence, Resident B refused to be interviewed; he indicated "I have nothing to say."

Resident C admitted he observed some type of interaction between staff, Mr. Tucker and Resident A, but he would not say what that interaction was. He refused to answer any other questions.

Resident D was interviewed by the DHS Worker and this Consultant on May 2, 2013. Resident D denied seeing or knowing anything about the incident. When it was brought to his attention that he was reported in the room at the time of the incident, Resident D indicated he was asleep.

This Consultant spoke with the Quality Manager, Britany Gatewood on April 24, 2013; and Ms. Gatewood indicated Mr. Tucker reported he entered Resident A room to de-escalate the resident, who was banging on his room door. She indicated when she questioned the residents noted herein, they were not receptive to answering questions, Resident B and Resident C refused to write a statement, but Resident A reported Resident A hit Mr. Tucker and Mr. Tucker hit Resident A back.

Midnight Shift Supervisor, James, Abercrombie, Youth Specialists, William White, and Glenn Johnson were interviewed by this Consultant and the DHS Worker on May 2, 2013. Youth Specialists, Alicia Wilson and Byron Tucker were interviewed on May 21, 2013 by telephone, by this Consultant. Each staff reported having updated restraint training; and all reported Resident A was upset, over the color of the uniform he was given; and he was sent to his room.

Mr. Abercrombie, employed by the agency for six and a half years, reported he responded to a loud noise and once he entered Resident A room he observed Resident A against his bed; and Mr. Tucker and Resident A were intertwined by their arms. He said Resident A was against the back corner room's wall; and it looked like a "blindside swoop" physical intervention gone wrong. That Mr. Tucker's left arm was locked with Resident A's right arm; and Resident A's struck Mr. Tucker in his

side three times with Resident A's free hand. Mr. Abercrombie said he grabbed Resident A's arm that was intertwined with Mr. Tucker's, stepped in between Resident A and Mr. Tucker and began verbally de-escalating Resident A. He asked Mr. White, who was reportedly steps away, telling Resident A to stop, to take Mr. Tucker out of the room. He then said he asked Mr. White and Mr. Tucker to leave the room, but he was not certain how they left, if one by one or if Mr. White escorted Mr. Tucker out of the room.

Mr. Abercrombie reported there was never a time that he saw Mr. Tucker hit or swing on Resident A. He said Resident D was standing in the room quietly; and he was not certain whether or not Resident B was in the room. Mr. Abercrombie indicated staff told him Resident A had become upset over the color uniform given him, he had targeted his anger at Mr. White; and Mr. Tucker had gone to talk with Resident A because he (Mr. Tucker) had a rapport with the resident.

Mr. White employed by the agency for eight years, indicated Mr. Tucker never hit or punched Resident A. He could not recall what other resident or residents were in the room.

Mr. White indicated Resident A was angry, but he had complied with staff's instruction for him to go to his room, then he stood in his doorway fussing loudly. He said Mr. Tucker was trying to de-escalate the resident; and he went to exchange the resident's uniform. He said Ms. Wilson called him to come back to the room and upon his return he observed Mr. Tucker and Resident A on the floor wrestling, "They were aggressively getting at each other". He denied seeing any punching, but said they were tussling. That Ms. Wilson was in the room telling Mr. Tucker and Resident A to stop. He said he tried to get in between the two, tried pulling them apart; he grabbed Resident A, who got loose, jumped on his bed and tried to go after Mr. Tucker. He said the resident and staff got intertwined, he called for help; and Mr. Abercrombie, with his assistance, was able to pull Resident A and Mr. Tucker apart. He indicated he grabbed Mr. Tucker and escorted him out of the resident's room; he said he had Mr. Tucker's arm.

Mr. Johnson an employee with the agency for almost nine years did not see the actual incident. He reported seeing Mr. Tucker and Mr. White coming out of Resident A's room, that Mr. White had Mr. Tucker's arm as if he was escorting him out of the room. He said the two staff were not talking. He indicated when he looked in the room Mr. Abercrombie was talking to Resident A; he couldn't recall if another resident was in the room.

Ms. Wilson, who said she had been in the hallway, across from Resident A's room, with Resident C, indicated Resident A was mad that he couldn't get his way, and Mr. Tucker was trying to see what the issue was. She said Mr. Tucker came to Resident A's door and proceeded into the room, even though she had advised him to wait for Mr. White. She said she had heard Resident A tell Resident D he was going to "F" a staff up; and she told Mr. Tucker this information. She indicated Mr.

Tucker acknowledged her warning, said he was fine, he knew Resident A was upset with Mr. White, and that he (Mr. Tucker) was going to talk with Resident A. She said Resident A's door was open and Mr. Tucker was talking to Resident A, trying to get the resident calm, when Resident A pushed Mr. Tucker. She said Mr. Tucker asked the resident why he pushed him, and then Resident A swung on Mr. Tucker, but she could not tell if his punch landed. She said she got out up and went into the room; and Mr. Tucker was still trying to calm the resident, assure him whatever the problem he would try to address it; and Resident A said he was tired of "bitch ass staff" and swung on Mr. Tucker again. She said Mr. Tucker tried to perform a "blindside swoop" physical intervention, but he was not able to connect to the resident/to complete it; and Resident A broke away. She said the two fell on the bed, she stepped away, called for assistance; and by then Resident A swung on Mr. Tucker again. She said Mr. White ran to the room, he grabbed Resident A and she tried to get Mr. Tucker; then they switched off and Mr. White took Mr. Tucker and was escorting him out of the room. She said Resident A got away from her, went after Mr. Tucker; and then Resident A, Mr. Tucker and Mr. White fell to the floor. She indicated Resident A kicked Mr. Tucker in the mouth, and punched him a couple of times. She sought out other staff's assistance, and Mr. Abercrombie came into the room, and she stepped out. She said the last thing she recalled was Mr. Abercrombie coming out of the room, followed by Mr. Tucker, then Mr. White.

When asked what was Mr. Tucker demeanor doing the incident, Ms. Wilson stated he was calm until Resident A swung on him; and that after the swing he was trying to restrain the resident. When asked about the video showing her touching the resident's door as if to stop Mr. Tucker's entrance into the room, she indicated he stopped and touched the door to tell Mr. Tucker about the physical threat she overheard Resident A making against staff, and she did not want to say that out loud. When asked about the video appearing to show Mr. Tucker rushing to the door and throwing something off his head, Ms. Wilson recalled Mr. Tucker having on a hat; and she was not sure what happened to it. She said everything happened quickly; and indicated there was never a time that Mr. Tucker swung on Resident A or that he was fighting or wrestling with Resident A.

Mr. Tucker reported Resident A was told staff would look for a uniform in the color he wanted, but he must go to his room. He said Resident A went to his room, but the resident was kicking his door and yelling. He said he went to Resident A's room to de-escalate him; and Ms. Wilson stopped him at the door, told him to wait for Mr. White due to Resident A being upset. He told Ms. Wilson he didn't think he should wait for Mr. White due to Mr. White being the person Resident A was upset with. He said Resident A was not mad with him, and he just wanted to talk with Resident A.

Mr. Tucker tried to calm Resident A down, asked Resident A to sit down on the bed, but the resident refused and got in his face. He said the resident said "staff was trying to treat him like a hoe ass nigga" and that "he was being punked" to wear a blue uniform. Mr. Tucker tried to get the resident to see it was no big deal, and if he complied with staff's instruction, he could get what he wanted. Resident A then

pushed him, Mr. Tucker stepped back, Resident A swung on him; and Mr. Tucker tried to restrain the resident. Mr. Tucker indicated he had Resident A's wrist and was taking him to the corner, and somehow another, they fell to the floor, in that corner. He indicated there was a 'bit of a wrestle', but not really, because it was just them both on the ground trying to get a loose. He indicated they only fell once; and he denied fighting, punching or trying to fight Resident A. He said everything happened quickly, and then staffs, Mr. White, Mr. Abercrombie, and Ms. Wilson were in the room. He said Mr. White and Mr. Abercrombie separated him and Resident A; and as they were getting up, Resident A kicked him in his mouth and busted his lip. After they both got up, Mr. Tucker said Resident A was still trying to come after him, Mr. Abercrombie grabbed Resident A; and Mr. Tucker walked out of the room, and Mr. White walked behind him. He denied being escorted by Mr. White, but acknowledged seeing video footage that appeared to show Mr. White had escorted him.

Mr. Tucker admitted he rushed to Resident A's room, but he denied being upset. He acknowledged having on a hat and throwing it on the floor. He realized he had it on, and said it was against the rules. He indicated he did what staff had done on several occasions when a resident was kicking on the door, that being, to go to the room to talk with the resident. He stated he discovered later that was not proper protocol. When asked if other residents were in the room during the incident, Mr. Tucker recalled Resident D being present egging Resident A on and laughing, and Resident B standing in the doorway "being nosey".

When asked if there were any marks or bruise to Resident A, Mr. White didn't notice any marks or bruises to Resident A; but indicated when he saw Resident A later, the resident showed him a couple of scratches on his right upper chest and shoulder. Ms. Wilson stated Resident A said someone scratched him on his shoulder, and she noticed what looked like three fingernail scratches. She said "I may have done it, but I'm not sure how it happened". Mr. Tucker didn't observe any marks or bruises to Resident A, at the time of the incident, but indicated he was later told Resident A marks.

Reviewed:

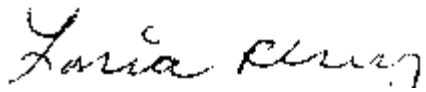
- Incident report.
- Witness statements from staff, one not legible for the staff's name and ones from Mr. Tucker, Mr. Abercrombie's, Ms. Wilson, Mr. Glenn.
- A witness statement from Resident A and Resident C indicating neither wanted to write a statement; and from Resident D indicating he was asleep, and just heard a lot of commotion.
- Body chart and Nurse's Remarks- indicating assessment and first aid provided, resident noted to have scratches to right shoulder.
- Physical restraint and staff Boundary policies.
- Video footage, showing Mr. Tucker approaching Resident A's room in what appeared to be a hurried state; and Ms. Wilson appearing to hold the door to block his entry into the room. Mr. Tucker threw an item off his head onto the

floor, and appeared to rush into the room. Resident C was observed in the hallway looking into the room. Resident B was seen in the door way then entering room, as was Ms. Wilson. Thereon Mr. Abercrombie was seen running down the hall and entering the room. Thereafter, Ms. Wilson exits the room, then Mr. White who appeared to be escorting Mr. Tucker, to have his hand on the back of Mr. Tucker's back/shirt area.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (i) Excessive chemical, mechanical, or physical restraint.
<b>ANALYSIS:</b>	The evident showed some variations in the staff reporting of the incident, but the evident did not support cruel and severe discipline or excessive restraint.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

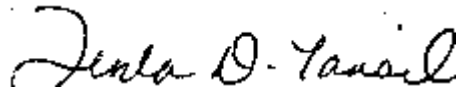
#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.

 June 22, 2013

\_\_\_\_\_  
Lonia Perry Date  
Licensing Consultant

Approved By:

 June 25, 2013

\_\_\_\_\_  
Linda Tansil Date  
Area Manager



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

September 3, 2013

Sax Guthery  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2013C0420045  
Detroit Capstone

Dear Mr. Guthery:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2013C0420045
<b>Complaint Receipt Date:</b>	07/19/2013
<b>Investigation Initiation Date:</b>	07/22/2013
<b>Report Due Date:</b>	09/17/2013
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE



## II. ALLEGATION(S)

Youth A was physically restrained by staff, Brian Collins, Edgar Jones and Nicholas Hayes on 7/17/13. Youth A reported Mr. Collins, Mr. Jones and Mr. Hayes stated that they were going to snap his arms. Youth A was taken to Children's hospital and was diagnosed with muscular skeletal pain.

## III. METHODOLOGY

07/19/2013	Special Investigation Intake 2013C0420045
07/22/2013	Special Investigation Initiated - Telephone Spoke with DHS Worker
07/24/2013	Contact - Face to Face Interviewed Youth A, Youth B, and staff, Edgar Jones, Nicholas Hayes, Brian Collins, Demitruis Porter
07/24/2013	Contact - Document Received Incident report. restraint policy
07/30/2013	Special Investigation Full Compliance
08/16/2013	Comment- Exit confirmation

### ALLEGATION:

Youth A was physically restrained by staff, Brian Collins, Edgar Jones and Nicholas Hayes on 7/17/13. Youth A reported Mr. Collins, Mr. Jones and Mr. Hayes stated that they were going to snap his arms. Youth A was taken to Children's hospital and was diagnosed with muscular skeletal pain.

### INVESTIGATION:

On July 24, 2013, Youth A, Youth B, and Youth Specialists, Edgar Jones, Brian Collins, and Nicholas Hayes were all interviewed by this Consultant and the DHS Worker. Youth Specialist, Demitruis Porter was also interviewed on July 24, 2013.

Youth A reported his right forearm hurt because Mr. Collins and Jones restrained him a little too hard. He indicated a week prior to this interview, he was fighting, he swung on Youth B; and Mr. Collins and Mr. Jones grabbed him. He said Mr. Collins was on one side of him, Mr. Jones on the other, and they put him up against the wall and pushed him arms up. He said and Mr. Collins said "I'm going to make sure you don't swing on anyone else", and Mr. Collins pushed his (Youth A's) arm up; and Youth A said he heard a 'pop". He reported seeing, Nurse Miller; and then being taking to the hospital. Youth A said "the doctor said it was a pulled muscle". Youth A said this was his first restraint since being placed at Capstone, from Washington, D.C, and that he thought Mr. Collins hurt him on purpose.

Youth B said Youth A gave him a cheap shot, and hit him from behind. He said staff kept him from fighting back, and handed him off to Mr. Porter to calm him down. He said the staff had Youth A up against the wall, he heard Youth A say "come on man I'm not gonna do no more". Youth B said he couldn't see what the staff was doing.

Mr. Jones and Mr. Collins both reported Youth A became irate while in the cafeteria, he did not respond to Mr. Collins instruction; and Youth A hit Youth B. Both indicated that once Youth A was escorted to his room, Youth A struggled to get free. That once in the room Youth A attempted to assault Mr. Collins; and when Mr. Jones attempted to restraint him, Youth A used the room's partition to kick off of, and Youth A and staff fell.

Mr. Jones said he came forth to assist Mr. Collins; and as he moved toward Youth A, Youth A reached out and hit Youth B. Mr. Collins then grabbed Youth A's right wrist; he grabbed the resident's left arm, and they put Youth A against the wall. He indicated after assistance was called, he released Youth A just before Youth A calm down; and Mr. Collins held Youth A on the wall. Mr. Jones said he never heard Mr. Collins say anything to Youth A other than calm down, "we both did". He said Youth A never said, stop, it hurt, hah or anything, but the usual comments that residents say to get let go. Mr. Jones said he never saw Mr. Collins bring Youth A's arm upward.

Mr. Jones said he and Mr. Collins escorted Youth A to Youth A's room; and Mr. Collins still had Youth A's arm. He said once they got Youth A into his room, Youth A swung on Mr. Collins, and Mr. Jones performed a blindside swoop and grabbed one of Youth A arms. Mr. Jones said while he was trying to get Youth A's other arm Youth A kicked off of the wall partition with his left foot, and he and Youth A fell. He said Youth A tried to break his wall with his right arm and landed on that side. He said Youth A was still struggling; he grabbed Youth A and put him in the settle position. He said Youth A said his arm hurt, so he let Youth A go. He said Mr. Collins was in the doorway when he placed Youth A in the settle position; he was not sure what Mr. Collins was doing when, he (Mr. Jones) and Youth A fell.

Mr. Collins indicated that while in the cafeteria Youth A assaulted Youth B with a closed fist to the jaw or shoulder. Mr. Collins said he grabbed Youth A by his arm and took the arm to the resident's back. He said Mr. Jones took Youth A's other arm and they pressed him to the wall and called for assistance. He said there was never a time that he along had Youth A to the wall. He said once other staff cleared the other residents from the area, he and Mr. Jones escorted Youth A to his room; and Youth A struggled to get free, and made threats toward another kid. Once in the room he indicated he had Youth A to sit on Youth A's bed; and when Mr. Collins back was turned to leave, Youth A attempted to swing on him, and Mr. Jones intervened with a blindside swoop. He said at that time Youth A kicked off of the room's partition and they fell. He said Youth A tried to break him fall with his arm, he was not sure which arm; and then Youth A complained that his arm hurt. Mr.

Collins said Mr. Jones placed Youth A in the settle position, and the nurse and supervisor were called.

Mr. Hayes did not witness the physical management of Youth A in the cafeteria. He reported observance of Youth A's escort, and what happened in Youth A's room. He said Mr. Collins had Youth A in the escort, and Mr. Jones opened the door. He said once Mr. Collins turned to leave, Youth A swung on Mr. Collins; and Mr. Jones, who was closer to Youth A, grabbed Youth A. He said Mr. Jones did a blindside swoop, had both of Youth A's arm; and Youth A kicked off of the partition causing Youth A to fall, and both Youth A and Mr. Jones fell. He said after Mr. Jones placed Youth A in the settle position, Youth A said my arm, and the supervisor and nurse were called.

Mr. Porter reported witnessing the incident in the cafeteria, not Youth A's escort or the incident in Youth A's room. He corroborated Mr. Jones and Mr. Collins' reporting of what occurred prior to Youth A being physically managed. He said Mr. Collins and Mr. Jones physically managed Youth A against the wall. He said there was never a time that he saw Youth A being held against the wall by only Mr. Collins. He denied hearing Youth A say anything about his arm at that time, or ever hearing Mr. Collins say to Youth A anything like making sure you don't swing on anyone else.

Reviewed:

- Incident report.
- Children Hospital discharge noting musculoskeletal pain.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (i) Excessive chemical, mechanical, or physical restraint.
<b>ANALYSIS:</b>	The evidence does not support excessive physical restraint: Youth A in his attempt to resist the restraint kicked off of a wall partition causing him and staff to fall. When he fell Youth A landed on his arm, likely inadvertently causing his injury.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.



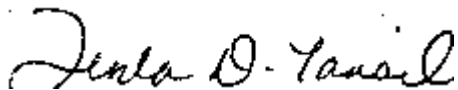
August 30, 2013

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Lonia Perry  
Licensing Consultant

Date

Approved By:



September 3, 2013

Linda Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

December 18, 2013

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2013C0420049  
Detroit Capstone

Dear Mr. Ziglor:

Attached is the Special Investigation Report for the above referenced facility. As indicated in the report a violation was found, but based on action already taken no further correction action is required.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2013C0420049
<b>Complaint Receipt Date:</b>	08/22/2013
<b>Investigation Initiation Date:</b>	08/26/2013
<b>Report Due Date:</b>	10/21/2013
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Resident A alleged sexual assault by staff, Orice Dennis. She reported Mr. Dennis" fingered me"

## III. METHODOLOGY

08/22/2013	Special Investigation Intake 2013C0420049
08/23/2013	Contact - Document Received Incident Report, Children service report, Mr. Dennis written statement
08/26/2013	Special Investigation Initiated - Telephone Spoke with Clinical Director Pernell Ziglor
08/27/2013	Contact - Telephone call made Spoke with DHS Worker
08/28/2013	Contact - Telephone call made Call to and from DHS worker
09/03/2013	Contact-Document received Email from Mr. Ziglor
09/03/2013	Contact-Telephone call made Spoke with Mr. Ziglor
09/11/2013	Contact- Face to face Spoke with Director, Sax Guthery, Interviewed Resident A, Resident B, Resident C , Supervisor, Michael Proffett, and Youth Specialists, Orice Dennis and Veronica Williams
09/13/2013	Contact- Face to face Interview of Resident A- at "Kid Talk" by interviewer, Amanda Fitz - DHS Worker, this Consultant , and GAL, Linda Hansen present
10/21/2013	Contact-Telephone made Spoke with Mr. Ziglor
10/24/2013	Comment Consultation with Area Manager, Linda Tansil
10/24/2013	Special Investigation-Sub Compliance
12/4/2013	Comment- Exit – Outcome confirmation

### ALLEGATION:

Resident A alleged sexual assault by staff, Orice Dennis. She reported Mr. Dennis" fingered me"

**INVESTIGATION:**

Resident A report Mr. Dennis fingered her in her vagina on two separate occasions, once downstairs in the laundry room, and once in her room. Resident A was not certain of the exact day of the incident, but reported it would have occurred, on a Saturday afternoon, the third or fourth week in July or first week in August of 2013.

Resident A reported Mr. Dennis had asked her to help him cleanup the hallway, which she did, by straightening the resident's shoes. Then they took a laundry basket downstairs; and while in the laundry room, Mr. Dennis unbuttoned her jumper, put his hand in her bra, stuck his finger in her mouth, stuck his hand down her pant and "fingered me in my vagina area". She said neither she nor Mr. Dennis said anything during the time Mr. Dennis was doing what she described; and that no other staff or resident was in the area at the time. She indicated she did not say anything because she was "shy and scared and didn't know what was happening". She indicated when "he did it in the laundry room she started bleeding. When asked if she was her getting her menstrual period at the time, Resident A said it wasn't her period.

Resident A reported approximately one to two weeks prior to the above incident happening "he did the same thing", to her earlier, that "he fingered me in my room". Resident A said she was in the group room, and Mr. Dennis came and asked her to help him put the mattress on the bed, because the ceiling had leaked and the mattress had been removed (It is noteworthy that the ceiling leaking was explored and no concerns were noted; and Resident A reported currently residing in a different room than the one she was in at the time of the alleged incident). She indicated her roommates were not present in the room; that Mr. Dennis did not say or ask her anything, he just began touching her. Resident A said she did not say anything, or yell out while Mr. Dennis touched her. She reported due to being afraid she did not tell another Capstone staff, an administrator, or another resident of the incidents after its occurrence.

She indicated after it happened a second time, she told Mr. Proffett on August 22, 2013 because "I got mad". She heard rumors from other female residents, and one resident said she knew Mr. Dennis fingered her (Resident A); so Resident A told Mr. Proffett that the rumors were true. She said a couple of days before she told Mr. Proffett, she told Resident C, Resident D, Resident E and Resident F (who wrote written statements). She said she told Resident C the day after the incident happen in her room; and that Resident C was the resident she told everything about both incidents.

Resident A indicated a week prior to telling Mr. Proffett, Mr. Dennis begged her not to tell anyone. She indicated she later heard it was rumored Mr. Dennis had raped her, and she reported she never said that. She said Mr. Dennis never said anything inappropriate to her, but every time she saw him he would touch her cheek or put his hand in her bra. That Mr. Dennis would get upset when she talked with male



residents; because he wanted her to give him every bit of her time. She denied awareness of Mr. Dennis being inappropriate with any other residents.

After telling administrative staff about the incident, Resident A saw a nurse, and was sent to the hospital. She reported being discharged from the facility to the hospital on August 22, 2013; and returning to the facility on August 28, 2013.

Supervisor, Michael Proffett, Director, Sax Guthery and Clinical Director, Pernell Ziglor all spoke with Resident A about her allegations. Each reported Resident A was unable to report an exact date that the incident occurred; and she said she was “fingering” by Dennis in the laundry room, and that she was by herself.

Mr. Proffett reported Resident A asked to talk with him and he reported the incident to Mr. Guthery and Mr. Ziglor. He, as did Mr. Guthery, indicated Resident A showed no emotional upset when reporting the incident. Mr. Proffett said she was more concerned about a note book; and she reported not wanting to be at the facility. Mr. Guthery indicated when Resident A realized she was getting Mr. Dennis in trouble, that she could not get a juice, she whined. Mr. Ziglor indicated Resident A’s emotional responses were not aligned with her allegations of being sexually abused. He assessed that her emotional responses were like that of a jealous girlfriend.

Mr. Guthery indicated Resident A reported the incident happened twice, that the first time was when Mr. Dennis came and got her from the group, and it happened in her room. The next time, the incident occurred in the laundry room. Mr. Guthery indicated he did not speak with Mr. Dennis about Resident A’s allegations; he made sure the supervisor obtained Mr. Dennis’s statement.

Mr. Ziglor indicated Resident A reported the incident occurred one Saturday at the end of July or early in August. He, as did Mr. Guthery, indicated Resident A reported she did not report the incident because she wanted it to happen. Mr. Guthery said Resident A indicated the incident was consensual; and that he had to explain to Resident A how an inappropriate sexual act by a staff with a resident could not be consensual.

Mr. Ziglor indicated after Resident A reported the incident, all reporting requirements occurred, including contact to the police on August 22, 2013. He reported Resident A was sent to the hospital after the disclosure; and her affect upon leaving was happy. He indicated Resident A had not reported an incident with Mr. Dennis occurring in her room.

Mr. Ziglor indicated Mr. Dennis accommodating the residents as he did, and Mr. Dennis’ lack of communication to administrative staff that there was a staffing boundary concern, was of policy issue. He indicated Mr. Dennis knew Resident A had an attraction to him, that “she would go crazy” when Mr. Dennis came on the unit; and Mr. Dennis never told anyone.

Resident B did not witness the incident related to Resident A and Mr. Dennis. She reported hearing rumors that sexual allegations were made against Mr. Dennis and there was proof. She did not know what the alleged proof was, but reported "Mr. Dennis is a really good staff and the allegations are all wrong". She indicated Mr. Dennis would talk with residents about issues and take time out with residents when other staff would not. She said some residents would ask him to use the bathroom, and then when he would open the door, 'they would say out loud get out of that grown man's face". She indicated the latter was a teasing remark made by some residents and the remark might be why someone might think he was being sexual. She indicated he was not; and that when residents were being sexual, he would report it. She indicated she knew from casual conversation with him, he had a wife and kid; and she does not believe the allegations. She indicated Mr. Dennis is a "father figure who understands and give encouraging advice".

Resident C reported she and Resident A used to be roommates; and that Resident A told her about both of the incidents. She said Resident A told her that Mr. Dennis "fingered her" and a couple of weeks after that Resident A said Mr. Dennis did it again and she (Resident A) started bleeding. Resident C could not recall the actual dates Resident A told her about the incidents, and did she report the matter to facility administrators.

In terms of actually witnessing inappropriate behaviors between Mr. Dennis and Resident A, Resident C indicated witnessing Resident A coming on to Mr. Dennis. She said Resident A would kiss Mr. Dennis on his cheeks a lot; and sometimes, but not all the times, Mr. Dennis would push Resident A away. She said that some times when Mr. Dennis would push Resident A away, he would tell Resident A "you're bad girl". She reported Mr. Dennis would often come mop Resident A and her room, and Resident A and Mr. Dennis would be playing back and forth. That sometimes Resident A would go behind the partition in their room and she would start taking off her clothes, and she and Mr. Dennis would tell Resident A to stop. That Mr. Dennis would tell Resident A she was going to get him in trouble.

Resident C indicated Mr. Dennis would come to their door often and he seemed to make a point to come to their group, but she never saw Mr. Dennis kiss Resident A or touch Resident A inappropriately. She had observed Mr. Dennis touch the top of Resident A's head and heard him say "you're a bad girl" but nothing sexual. Resident C had also observed Resident A get Mr. Dennis to go into the clothing closet of the gym with Resident A. She said Resident A made an excuse of needing to get a ball or something, and then the two when inside the closet, with the door open; and Resident A tried to kiss Mr. Dennis. That Mr. Dennis pushed Resident A away and called her a bad girl.

Resident C reported Resident A was obsessed with Mr. Dennis; and staff would say that. She said Resident A would say she wrote Mr. Dennis a letter about having sex; and she observed Resident A hand Mr. Dennis two or three letters, but Resident C did not read the letters, or know what the letters said. She also

observed that Resident A had Mr. Dennis' name in her (resident A) Journal, but Resident C did not know any details about the journal. She indicated "Mr. Dennis use to talk with" Resident A "like a dad" and would encourage Resident A to journal when Resident A would talk about being raped in the past or about bad situations.

Orice Dennis reported working at the facility for four years. He acknowledged familiarity with Resident A, but denied the allegations as reported by Resident A. He reported an "ordinary" cordial relationship with the resident and indicated she always spoke with him. He acknowledged he may have had Resident A straighten the residents' shoes in the main hallway that he cleaned one day, or had her to sweep an area, but nothing more. He said Resident A was not a 'captain' and would not have been assigned those types of activities. He said he never squeeze Resident A's cheeks nor touched her inappropriately, in her room, or anywhere else. He reported trying to do whatever he could to help all the residents, and that most residents knew he would take time out for them. That many times when he walked down the hallway, residents, including Resident A banged on their door wanting his attention. He said a resident trying to get his or other staff's attention was normal. He said sometimes he would stop to talk with the resident, but most time he would not, due to being too busy with his tasks. He indicated there were occasions, a couple of weeks prior to these allegations whereby Resident A tried to get his attention and he told her no. He indicated Resident A had asked to talk with him and he told her he could not talk and he closed her door. That on another occasion, Resident A ran out of the transport line and tapped him on his arm trying to his attention and the staff with the group instructed Resident A to get back in line. In each of those times, Mr. Dennis said he told Resident A he could not talk with her; and he guessed Resident A may have taken offense to that.

Mr. Dennis surmised that Resident A and two other residents, who made inappropriate verbal comment claims against him, may have made allegations because he refused to transport notes to the male residents. He said the girls were always trying to get notes to the boys, and that after he told them no, "that turned to something else; that after that they were not as cordial." He admitted his refusal pertaining to the notes was quite some time ago, but he could not pinpoint a date.

Mr. Dennis indicated disbelief at the allegations, and stated he worked hard to do his best to help the residents. He asked if this Consultant would interview his co-workers about him. When the investigative process was re-explained to him, including that a character search was not the focus of the investigation, Mr. Dennis acknowledged this, but asked this Consultant to talk with staff. When this Consultant asked what staff members would he want this Consultant to interview, he only indicated Ms. Yvonne Williams.

Youth Specialist, Yvonne Williams indicated she transported Resident A to the hospital the day the allegation was reported by Resident A. She reported Resident A could not give her a direct date of when the incident happen, and did not go into any

details. That Resident A reported Mr. Dennis “fingered her” in her vagina in the laundry room.

Ms. Williams reported working with Mr. Dennis for the past four years; she denied witnessing him being verbally or physically inappropriate with a resident. She said he treated all the residents the same “if they called him he came”. That whether boy or girl, Mr. Dennis “was at their beckon call”.

Attended Resident A’s “Kid’s talk” interview on September 13, 2013; at which time Resident A reported the information basically indicated to this Consultant when she was interviewed on September 11, 2013. Resident A also reported the following during the Kid talk interview, that:

- She had not been sexually active while in placement; and that she had been raped once prior to coming to Capstone.
- The incidents happened in late July 2013.
- That Mr. Dennis placed his finger in her vagina on four different times; three times on one day, at different time intervals in the laundry room, and once one to two weeks earlier, while she and he were in her room; she was standing.
- That when the incidents occurred in the laundry room, she had been with Mr. Dennis for about fifteen to twenty minutes in duration. That during one of the times he put his finger in her vagina, it was there a minute or two, and she started bleeding some doing the time that incident occurred, and also afterwards.
- That Mr. Dennis didn’t say anything to her when he put his finger in her vagina again, but later he said you know you are bleeding; and she told him “I’m not on my period.” That he said “you look like you are not a virgin” and that he said that because she was bleeding. Resident A said Mr. Dennis used two fingers; and stopped because they thought staff was coming.
- That Mr. Dennis had put his finger in her mouth; and he would pinch her cheeks and say she had baby cheeks almost each time that he saw her.
- That Mr. Dennis told her not to talk about what happened in the laundry room; and she agreed she would not. She reported hating Mr. Dennis for what he did and hating herself.

Reviewed:

- Incident report, which indicated Resident A said Mr. Dennis touched her in an inappropriate manner when she was asked to help sort laundry.
- A written statement from Resident C, which basically indicated what Resident C reported when interviewed; and indicated Resident A “has been talking to Mr. Dennis for some time”.
- A August 22, 2013 written statement from Mr. Guthery that indicated Resident A reported the incident between she and Mr. Dennis was consensual, and she wanted it to happen. That the incident happened twice, one time in the resident’s room and the other time on a Saturday in the second floor laundry room. That Resident A stated Mr. Dennis was really nice and she did not want

to get him in trouble. That she wanted to self-harm because of the incident; and when redirected focused on chips and juice, and indicated the latter items were more important at that time.


- An August 22, 2013 written statement from Mr. Dennis denying inappropriate conservation or contact with Resident A.
- An August 22, 2013 written statement from two female residents, at the time, (Resident D and Resident E ) that indicated Resident D said Resident A told her Mr. Dennis fingered her in the laundry room. Resident D's statement indicated Resident A told Resident D that Resident A and Mr. Dennis had a relationship and" they had kissed & stuff that's it". Resident E's statement indicated Resident A said blood came out after the incident; and there was blood on her shirt.
- An August 22, 2013 written statement from another resident (Resident F) that indicated Resident A told her Resident A liked Mr. Dennis but she (Resident F)never witnessed him openly touching Resident A. Resident F's statement indicated Resident A said he never touched or hugged her.
- Staff Boundary Policy, which indicated "Initiating or encouraging personal relationships of any kind with residents." is prohibited.

<b>APPLICABLE RULE</b>	
<b>R 400.4109</b>	<b>Program statement.</b>
	(1) An institution shall have a current written program statement which specifically addresses all of the following: (c) Policies and procedures pertaining to admission, care, and discharge of residents.
<b>ANALYSIS:</b>	<p>The evidence suggests:</p> <ul style="list-style-type: none"> <li>• Mr. Dennis spent an extra amount of time attending to female residents' requests for attention, including Resident A.</li> <li>• That other residents and staff, therein, likely Mr. Dennis were aware of Resident A's possible fascination with him, and that Resident A's fascination and repeated requests for attention from Mr. Dennis was not reported to facility administrators.</li> <li>• Mr. Dennis's lack of action to stop the repeated request for attention may have fostered the resident's inappropriate feelings for him; and this violated agency's policy.</li> </ul> <p>It is noteworthy that Mr. Dennis was terminated; and based on the facility's actions no further corrective action plan is required.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4112</b>	<b>Staff qualifications.</b>
	A person with ongoing duties shall be of good moral character, emotionally stable, and of sufficient health, ability, experience, and education to perform the duties assigned.
<b>ANALYSIS:</b>	<p>The evidence is inconclusive</p> <ul style="list-style-type: none"> <li>• No other resident or staff had direct knowledge of the incident.</li> <li>• Resident A told one resident nothing inappropriate occurred between she and Mr. Dennis and other residents something different.</li> <li>• Resident A's accounting of the incident increased in severity each time she reported the matter; and it is difficult to validate with certainty that the allegations, as reported by Resident A, occurred.</li> </ul> <p>If additional information presents itself, further investigation will occur.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.

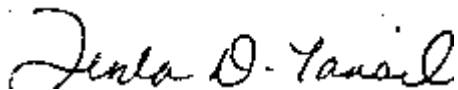


December 16, 2013

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



December 18, 2013  
\_\_\_\_\_  
Date

\_\_\_\_\_  
Linda Tansil  
Area Manager



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

October 10, 2013

Julie Avant  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2013C0420050  
Detroit Capstone

Dear Ms. Avant:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2013C0420050
<b>Complaint Receipt Date:</b>	08/14/2013
<b>Investigation Initiation Date:</b>	08/26/2013
<b>Report Due Date:</b>	10/13/2013
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE



## II. ALLEGATION(S)

On 8/13/13 during a physical restraint Youth A and staff fell, Youth A hit her head causing an injury and she received stitches.

## III. METHODOLOGY

08/14/2013	Special Investigation Intake 2013C0420050
08/14/2013	Contact - Document Received Incident report, children service document,
08/26/2013	Special Investigation Initiated - Telephone Spoke with Clinic Director Pernel Ziglor
08/27/2013	Contact - Telephone call made Spoke with DHS worker
08/27/2013	Contact - Face to Face Interviewed Youth A, Youth B, Staff, Katrina Jackson, Crizzanda Tucker and Kyshuan Powell
09/08/2013	Contact Document Sent Email to DHS Worker
09/16/2013	Contact Document Sent Email to DHS Worker
09/18/2013	Contact Document Received Email from DHS Worker
09/18/2013	Comment- Exit
09/18/2013	Special Investigation-Full Compliance

### ALLEGATION:

On 8/13/13 during a physical restraint Youth A and staff fell, Youth A hit her head causing an injury and she received stitches.

### INVESTIGATION:

Youth A reported she got mad after being told she could not have her room changed, she flipped over a chair; and was escorted to her room by Ms. Powell and Ms. Tucker. She said she was fighting and struggling to keep staff from taking her to her room, but not when they got her to the room. She said Ms. Powell went to get the "burrito" (protective restraint device); and Ms. Jackson took Ms. Powell's position in the escort. That Ms. Jackson was on her left, Ms. Tucker on her right and they were hurting her arms. That once the staff got her to her door, she didn't feel they pushed her, but she felt a force when they let her go. She indicated this force caused her to go face first into the wall; and then she hit her head on the frame of

the bed. She said there was no mattress on the bed. She said she was in a room by herself and that bed was not occupied by another resident. She reported after she hit her face/head she was bleeding and freaking out/ screaming, crying; and she tried to tell staff she was bleeding, and they were still trying to get her into the "burrito". She said Ms. Tucker stepped out and Ms. Jackson walked over to the bed and put her on the floor where the "burrito" was laid out. She indicated after they got her in the "burrito" she heard a male staff say "you need to set her up". She believed that male staff was Nurse Miller, or Mr. Oldham because both had arrived on the scene.

It is noteworthy that when Youth A was interviewed, she was observed to have a long diagonal healing scar, coming down her forehead toward her eye; and she had a black eye (right). She said she received eighteen stitches, nine inside and nine outside, the latter of which were removed on 8/20/2013. She stated that she believed her injury was not an accident, that if it was accident she and the staff all would have fallen and there would not have been such a force. She acknowledged when staff realized she was hurt they called for an ambulance. She said the nurse and Ms. Powell seemed concerned; she did not pay attention to the other staff. Youth A indicated Youth B witnessed the incident from Youth B's room, which was located across from Youth A's'.

Youth B reported she was watching the incident from her room until Mr. Oldham came and screamed to her to get out of her door. Youth B reported Youth A was escorted to Youth A's room by Ms. Tucker and Ms. Jackson; and once inside the room, they were trying to get Youth A up against the wall. Youth B indicated Youth A was telling staff to get their hands off her, but she was not resisting. She indicated the staff shoved Youth A into the wall and Youth A hit her face on the wall. She said as soon as Youth A's head hit the wall blood was everywhere. Youth B said Ms. Washington brought the "burrito: and the staff were still trying to get Youth A into it. Youth B said Ms. Oldham asked Ms. Powell what happened; but Youth B was not sure where Ms. Powell came from.

Youth Specialists, Katrina Jackson, Crizzandra Tucker, and Kyshuan Powell all indicated Youth A was upset over wanting her room changed, threw a chair and was escorted to her room. That during the physical management Youth A was verbally and physically aggressive during the escort and in the youths' room. They denied pushing or shoving the youth.

Ms. Jackson reported Ms. Tucker and Ms. Powell were getting ready to escort Youth A; but she stepped forward and replaced Ms. Powell. She indicated Youth A was verbally and physically aggressive, jerking away, screaming, and hollering during the escort; and that her resistance escalated once they got her into her room. Ms. Jackson said the youth's arms were behind the youth's back; and once she and Ms. Tucker got Youth A near the first bed in Youth A's room, they all fell on that empty bed, which did not contain a mattress. Ms. Jackson said she fell on the side of the bed, Youth A fell on the bed; and she was not certain where Ms. Tucker fell. She

recalled seeing blood, and trying to assert where the blood was coming from. She said there was a lot of blood on the bed; and that Ms. Tucker was also inquiring about the blood, and then they discovered the blood was coming from Youth A. She said Youth A was saying her face was hurting, and when they got Youth A into the settle position Youth A had a lot of blood on her face. When asked by this Consultant if they were still trying to put Youth A into the "burrito" at this point; Ms. Jackson indicated they were not, that at this point they called the nurse. She indicated when they escorted Youth A to her room they were going to use the 'burrito: because Youth A was out of control, but when Ms. Powell got back with the device Youth A had fallen. Ms. Jackson said Ms. Powell threw the device down, Ms. Powell never put her hands on Youth A; and she nor Ms. Tucker pushed Youth A into the wall. Ms. Jackson was not really sure how Youth A got the cut on her face.

Ms. Tucker indicated Youth A had been allowed to talk with the supervisor pertaining to getting her room changed, but when Youth A returned to the activity room, Youth A was upset and threw a chair. She indicated redirecting the youth had not been effective, and she and Ms. Powell were escorting the youth to her room, when Ms. Jackson stepped in and replaced Ms. Powell. She said Youth A was resisting the escort, and once in the youth's room Youth A was screaming, cussing, and trying to pull out of the physical management. She said she and Ms. Jackson got Youth A in front of Youth A's bed, they were still holding Youth A, but Youth A was still struggling, despite attempts to get Youth A to calm down. She said Youth A was kicking at them and trying to pull away, saying let me go bitch; and they fell on Youth A's bed frame. She said the mattress had been moved from the youth's bed, due to their policy related when a youth is escorted to their room due to behavior issues.

Ms. Tucker reported Youth A's kicking may have been what tripped them, causing them to fall. She said when they fell she fell beside Youth A, and she still had one of Youth A's arms. She did not see Youth A hit anything on the bed, but acknowledged hearing Youth A scream "my face". Ms. Tucker said when Youth A said her face, she and Ms. Jackson saw Youth A's face was cut and bleeding. She reported there was lots of blood and she could see a gash.

Ms. Tucker said there never was a time that she Ms. Jackson or Ms. Powell pushed Youth A against a wall; or that staff had Youth A up against a wall. She said Ms. Powell was not in the room when they fell; that Ms. Powell had gone to get the 'burrito", and when Ms. Powell returned they had fallen and they did not try to put Youth A into the burrito device. She said Ms. Jackson called the nurse, Nurse, Miller examined Youth A and staff, Ms. Williams accompanied Youth A to the hospital.

Ms. Powell corroborated Ms. Jackson and Ms. Tucker's report about Ms. Powell being replaced in Youth A's escort, and that Youth A was verbally and physically aggressive during the escort, and once they got Youth A to her room. Ms. Powell indicated they all tried to deescalated Youth A, that she advised Youth A to calm down, and Ms. Jackson and Ms. Tucker "were begging and pleading" with the youth to do so, telling her that they did not want to restraint her. Youth A would not calm

down, and Youth A was kicking at staff; and so Ms. Powell made the decision to get the “burrito”. She indicated Youth A was standing in the middle of the room when she left from the door; and when she arrived back with the burrito device, Ms. Jackson and Ms. Tucker were trying to get Youth A up from the bed/not Youth A’s bed. Ms. Powell said she saw lots of blood, that Youth A had blood in her hair, on her face; and Youth A was saying she was sorry and he wanted to sleep. Ms. Powell said the nurse was called. Ms. Powell did not see the fall.

Reviewed:

- A written statement from Youth A dated 8/14/13 which indicated” I don’t really know what happen Because it all happened so fast all I remember is that somehow my face hit the bed and my head hit the wall.” That Ms. Tucker said she tripped but Youth B said she saw otherwise. The statement went on to indicated what Youth A said in her verbal interview about bleeding, staff still trying to put her in the burrito and her receiving eighteen stitches and a black eye.
- A written statement from both Ms. Jackson and Ms. Tucker, which were both dated 8/13/13. Both statements indicated the youth was physically managed, and because of the youth resisting, staff and youth fell on the bed.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (i) Excessive chemical, mechanical, or physical restraint.
<b>ANALYSIS:</b>	<p>The evidence does not support excessive mechanical or physical restraint.</p> <p>The youth was kicking and struggling during the physical management causing staff and youth to fall; and the youth fell and hit her face on the bed frame which cause her forehead cut and eye injury.</p> <p><b>Consultation:</b> Exploration of a way to safeguard the bed frames/protect residents from injuries due to potential falls, given the bedframe’s material make up, is recommended.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.




October 6, 2013

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Lonia Perry  
Licensing Consultant

Date

Approved By:



October 10, 2013

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Linda Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

October 29, 2013

Julie Avant  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2013C0420056  
Detroit Capstone

Dear Ms. Avant:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2013C0420056
<b>Complaint Receipt Date:</b>	08/30/2013
<b>Investigation Initiation Date:</b>	09/05/2013
<b>Report Due Date:</b>	10/29/2013
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Youth A alleged she was choked on the stairwell by staff, Mr. Hayes.

## III. METHODOLOGY

08/30/2013	Special Investigation Intake 2013C0420056
09/05/2013	Special Investigation Initiated - Telephone Spoke with DHS worker
09/11/2013	Contact - Face to Face Interviewed Youth A. Therapist, Paige Henry, and viewed video footage
09/11/2013	Contact - Telephone call received Spoke with Youth Specialist , Nicholas Hayes
09/11/2013	Comment- Exit
09/12/2013	Contact-Telephone Received Spoke with DHS Worker
09/12/2013	Special Investigation Completed- Full Compliance

### ALLEGATION:

Youth A alleged she was choked on the stairwell by staff, Mr. Hayes

### INVESTIGATION:

Therapist, Paige Henry reported Youth A disclosed during a therapy session that Mr. Hayes choked her on the stairs, while he was escorting her upstairs after a verbal behavior issue. That Youth A said when she stopped to pick up a piece of tape on the stairs, Mr. Hayes, who was behind her, pushed her up against the wall, put his hand on her neck and choked her.

Ms. Henry indicated Youth A did not report she had any trouble breathing; and gave no other details, than that she was choked. Youth A did indicate she felt violated. Ms. Henry reported Youth A “is not a kid to just make blatant, malicious, intentional allegations”. She indicated Youth A is a difficulty kid, and she would not put it pass someone to do what Youth A alleged. She also indicated that given Youth A’s past history of sexual abuse, if hands were placed on Youth A, the touch, in close proximity, may have been more emotional to Youth A than the physical choking. And that Youth A’s complaint could be partially allegation and partially about the touch.

Youth A reported she had “gotten into it with staff, Ms. Lewis”, Mr. Hayes escorted her from the outside courtyard upstairs, and he choked her on the stairs. She said she was walking on her own during the escort. That Mr. Hayes was behind her, and when she grabbed a pick of tape from the floor, Mr. Hayes grabbed her by neck, and



told her to give him the tape. She indicated Mr. Hayes did not voice a concern when she took the tape from the wall, but did as she was playing with it and after she dropped it and went to pick it up. Youth A indicated she later heard Mr. Hayes said he thought she would use the tape to self-harm; she denied being a self-harmer.

When asked if Mr. Hayes physically choked her, Youth A indicated "he put one hand around my neck, but he didn't squeeze". She indicated she told him to get the "fuck off me", he moved, and she dropped the tape on the floor. She indicated no one else witnessed the incident, and that "I feel violated".

Youth Specialist, Nicholas Hayes denied the allegations. He indicated he never touched Youth A's neck, did not choke her; and the camera showed that. He indicated he was walking behind Youth A as he escorted her upstairs. That Youth A grabbed a piece of tape off the wall, he asked her several times to give him the tape and she would not. He indicated he reached for the tape, Youth A aggressively pulled away, he grabbed Youth A's shoulder, and she handed him the tape. Thereafter he continued the escort.

Reviewed:


Facility camera footage which showed:

- Youth A and Mr. Hayes on the stairs going upward.
- Youth A with something in her hand. Mr. Hayes appearing to try to retrieve the object by placing his right hand on Youth A's collar and reaching with his left hand to try to get the object.
- At no time Mr. Hayes pushing the youth against a wall or putting his hand around her or choking her.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of severe physical discipline inflicted in any manner.
<b>ANALYSIS:</b>	The evidence does not support cruel and severe discipline; visual evidence showed the youth was not choked by the staff.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing staff is recommended



October 28, 2013

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Lonia Perry  
Licensing Consultant

Date

Approved By:



October 29, 2013

Linda Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

February 7, 2014

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2014C0420010  
Detroit Capstone

Dear Mr. Ziglor:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in this report, and special investigations 2014C042003, and 2014C0420011, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Based on the cumulative issues pertaining to all three special investigations, upon receipt of an acceptable corrective action plan, a six-month provisional license will be issued. If you do not agree to a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. You must still submit an acceptable corrective action plan.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2014C0420010
<b>Complaint Receipt Date:</b>	01/14/2014
<b>Investigation Initiation Date:</b>	01/17/2014
<b>Report Due Date:</b>	03/15/2014
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Youth A was slapped in the face by staff, Douglas Hill; and a supervisor witnessed the incident.

## III. METHODOLOGY

01/14/2014	Special Investigation Intake 2014C0420010
01/17/2014	Special Investigation Initiated - Face to Face Spoke with facility Director
01/17/2014	Contact - Face to Face Interviewed Youth A
01/23/2014	Contact - Telephone call made Left message for staff, Turner Marshall
01/24/2014	Contact - Telephone call received Spoke with Turner Marshall
01/28/2014	Contact - Telephone call made Left message for Mr. Douglas Hill
01/28/2014	Contact - Telephone call received Spoke with Mr. Hill
01/31/2014	Contact - Telephone call made Spoke with Youth Specialist, Jazmone Belton
01/31/2014	Comment- Emailed rule violation to Director, Mr. Ziglor
02/06/2014	Inspection Completed- BCAL Sub. Non-Compliance

### ALLEGATION:

Youth A was slapped in the face by staff, Douglas Hill; and a supervisor witnessed the incident.

### INVESTIGATION:

Youth A(16), Supervisor, Turner Marshall, and Youth Specialist, Jazmone Belton, all reported Mr. Hill slapped or assaulted Youth A.

Youth A reported he was standing on top of the "stall" (a partition in the room that separated the toilet from the bedding area) trying to break the ceiling light when Mr. Hill told him to get down and he refused. Youth A reported he then spit at Mr. Hill who then came over the "stall" and slapped him on the left side of his face. He said

Mr. Marshall entered his room and “saw it”. Mr. Marshall said Mr. Hill was fired. Mr. Hill walked out and down the hall.

Youth A reported seeing the facility nurse, but denied any marks or bruises from being slapped.

Mr. Marshall indicated Youth A was having a bad day when he was called on Youth A’s unit. He said when he arrived, Mr. Belton had deescalated Youth A, but Mr. Hill was talking back and forth with Youth A, and indicated Youth A had spit on him. He indicated that while he was in the room, Youth A spit at Mr. Hill again. Mr. Hill wiped his face, reached around him (Mr. Marshall) and slapped Youth A in the face.

Mr. Marshall reported he terminated Mr. Hill on the spot, because he and Mr. Belton had Youth A under control, and all Mr. Hill had to do was to leave the area.

Mr. Douglas Hill, a prior ten year employee acknowledged Youth A had climbed on top of the partition in Youth A’s room, and was banging the ceiling light fixture. He said Youth A was banging his (Youth A) fist hard on the light fixture, and he (Mr. Hill) tried to stop Youth A from self-harming. Mr. Hill called the supervisor about the incident, but entered the room because Youth A ignored his directive to get down from the partition, said he was not going to stop until he broke the light, and said he was going to flood the toilet. Mr. Hill indicated Youth A got down. When he entered the room, Youth A had a roll of tissue, so he tried to grab the tissue, and Youth A spat in his face. He indicated he wiped his face, and Youth A spat in his face again, after Mr. Hill told him not to.

Mr. Hill reported he used his left hand to wipe his face, and used his right hand to touch Youth A’s cheek and turned Youth A’s head away. He denied slapping Youth A; he reported he used his hand to turn Youth A’s head so that Youth A couldn’t spit on him again. When asked if he had been trained on what to do if a resident spat at him, he responded he had, but denied being aware that Youth A was a spitter.

Mr. Hill said Mr. Marshall reported he (Mr. Hill) left the room when told, but then returned, reached around Mr. Marshall and slapped Youth A, but that is a lie. He said it would be hard for him to reach around Mr. Marshall to hit Youth A. He indicated had he slapped Youth A, who is White, Youth A’s face would have been red, but it was not. He reported no problems with Mr. Marshall or past disciplinary actions, and suspected his termination was a ploy to get rid of some staff. He said after the incident he was not given an opportunity to tell Mr. Marshall what happened, why he went into Youth A’s room, or to write a statement or incident report, which was protocol.

When asked if another staff witnessed the incident Mr. Hill reported there was another staff, but he did not want to name that staff for fear of causing problems for that staff.

Mr. Belton, an employee since July, 2013, reported he was in the room at the time of the incident. When he arrived Youth A was “irate”, not listening to Mr. Hill’s directive, and Youth A’s anger was directed at Mr. Hill. He said he was able to take both of Youth A’s arms and had them behind the youth’s back to escort him into the hallway. He said he was facing Youth A’s back; and he told Mr. Hill to step back. He said Mr. Hill was still in the room; and when Youth A realized he could not do anything more to Mr. Hill, Youth A attempted to spit on Mr. Hill. He said Youth A spat at Mr. Hill twice; and after the second time, Mr. Hill swung on Youth A. He said from how he was standing it appeared as if Mr. Hill’s swing landed on the youth’s shoulder.

When asked if Mr. Hill had been instructed to leave the room, Mr. Belton acknowledged that Mr. Hill had by Mr. Marshall. He said” right as Mr. Hill was attempting to leave was when” Youth A spat on him. He said Mr. Hill was facing Youth A; and Mr. Marshall was kind of in front of the youth as well, but standing at an angle from the youth; and Mr. Marshall tried to step in front of the Youth A and Mr. Hill.

Reviewed:

Incident report dated January 13, 2014, related to Youth A, completed by Mr. Marshall that indicated:

- The incident report was for self- harming behavior and destruction of property.
- Youth A was attempting to breakout the light in the ceiling and staff quickly intervened and escorted him into the hallway.
- Staff attempted to de-escalate Youth A in the hallway; and when Youth A attempted to self-harm by biting his wrist, the youth was physically managed to prevent self-harm.
- Supervisor and nurse notified.
- No nurse’s follow up note.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of severe physical discipline inflicted in any manner.



<b>ANALYSIS:</b>	The statements from Mr. Marshall and Mr. Belton differ as to whether Mr. Hill slapped Youth A in the face, as reported by Mr. Marshall and the youth, but both staff indicated Mr. Hill assaulted the youth. Youth A and Mr. Marshall describe a slap and Mr. Belton describe a swing that appears to have landed on Resident A's shoulder. Both are severe physical discipline and not acceptable according to this rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### **ADDITIONAL ALLIGATION:**

During the course of the investigation it was alleged the facility did not follow protocol related to documenting the incident that occurred in Youth A's room related to Mr. Hill.

#### **INVESTIGATION:**

Mr. Hill indicated he was not allowed to write a written statement about the incident or to complete an incident report. He indicated he was immediately sent home without being asked or allowed to complete any form of written report.

The initial incident report provided to this Consultant, and authored by Mr. Marshall, did not indicate information related to staff Mr. Hill slapping Youth A; nor was a statement from Mr. Hill, which in many instances had been provided, from a resident(s) and alleged perpetrator. It is noteworthy that the facility did report the incident to Children's Services and BCAL.

A subsequent incident report provided by Director, Ziglor after the interview with Mr. Hill; and also authored by Mr. Marshall did indicate the alleged slap by Mr. Hill.

#### **Reviewed**

Facility's Incident Policy which indicated:

- Incident reports should be completed for situations of significance, such as "Abuse/Neglect allegations of resident".
- Incident Reports shall be written by the staff member most involved in the situation after the incident has de-escalated, by the end of the staff member's shift at the latest.
- No declaration that a statement from the staff was mandated.

A subsequent Incident Reported dated January 13, 2014, related to Youth A, completed by Mr. Marshall that indicated:

- During a de-escalation attempt Youth A spit on staff D. Hill and D. Hill made inappropriate contact with the youth by striking the youth face with an open palm.
- Youth A was Deescalated and staff was sent home; nurse and administrative staff notified.

<b>APPLICABLE RULE</b>	
<b>R 400.4109</b>	<b>Program statement.</b>
	(1)An institution shall have a current written program statement which specifically addresses all of the following: (c)Policies and procedures pertaining to admission, care, and discharge of residents.
<b>ANALYSIS:</b>	It is understandable that in light of Mr. Hill being immediately terminated and sent home, a written incident report from that staff may not have been prudent. And although it may have been an unwritten protocol for the facility to take a staff's written statement, about an alleged incident, doing so is not documented as mandated by the facility's policy.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **IV. RECOMMENDATION**

Due to the violation outlined in this report and the ones outlined in special investigations 2014C042003, and 2014C0420011, each in and of itself an issue of residents' safety, combined they suggest an additional level of concern requiring the facility's assessment and action. And while it is to the facility's credit that it acted swiftly and terminated the staff involved in each incident, a constant firing of staff as a corrective action plan is not an effective remedy for what may be something more deep-rooted.

Therefore, based on the findings pertaining to these three special investigations modification of the facility's license to a provisional license is recommended; upon receipt of an acceptable corrective action plan.

February 7, 2014

\_\_\_\_\_  
Lonia Perry Date  
Licensing Consultant

Approved By:

Linda Tansil  
Area Manager

**February 7, 2014**  
Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

February 6, 2014

**QUOTED PROFANITY IN REPORT**

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2014C0420011  
Detroit Capstone

Dear Mr. Ziglor

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in this report, and special investigations 2014C042003, and 2014C0420010, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

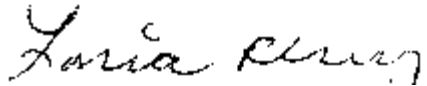
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Based on the cumulative issues pertaining to all three special investigations, upon receipt of an acceptable corrective action plan, a six-month provisional license will be issued. If you do not agree to a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. You must still submit an acceptable corrective action plan.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

A handwritten signature in cursive script that reads "Lonia Perry".

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2014C0420011
<b>Complaint Receipt Date:</b>	01/14/2014
<b>Investigation Initiation Date:</b>	01/15/2014
<b>Report Due Date:</b>	03/15/2014
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Resident A alleged she was assaulted by staff Ms. Coleman on 1/6/2014, and the staff closed the door on her on 1/10/2014.

## III. METHODOLOGY

01/14/2014	Special Investigation Intake 2014C0420011
01/15/2014	Special Investigation Initiated - Letter Email to DHS Worker related her 1/15/14 email
01/17/2014	Contact - Face to Face Spoke with Director Pernell Ziglor, interviewed Resident A, staff Tatiana Coleman, Christopher Purnell, and viewed camera video footage
01/22/2014	Contact - Telephone call made Attempted contact with, Ms. Chantel Simpson- number disconnected
01/22/2014	Contact - Telephone call made Attempt contact with Ms. Kimberly Anderson-- wrong Number
01/28/2014	Contact - Telephone call made Attempted contact with Ms. Simpson # disconnected
01/28/2014	Contact - Telephone call made Spoke with DHS Worker. Simpson and Anderson contact #s verified. # was incorrect for Anderson
01/31/2014	Contact - Telephone call made Attempted contact with Ms. Anderson, informed wrong #
02/06/2014	Inspection Completed- BCAL Sub. Non- Compliance

### ALLEGATION:

Resident A alleged she was assaulted by staff, Ms. Coleman, on 1/6/2014, and the staff closed the door on her on 1/10/2014.

### INVESTIGATION:

Director, Pernell Ziglor, indicated review of the facility's camera footage did not show Ms. Coleman hitting Resident A, but did show improper restraint techniques being used by Ms. Anderson and Ms. Simpson. The facility uses the Handle With Care

Behavioral Management physical intervention technique, and Ms. Anderson and Ms. Simpson failed to use proper physical management intervention with Resident A. He reported those staff members were terminated; and Ms. Coleman was suspended due to her involvement.

Resident A, Youth Specialist, Tatiana Coleman, and Food Service Coordinator/Supervisor, Christopher Purnell were all interviewed by this Consultant and the DHS Worker.

It is noteworthy that some of Resident A's reporting was confusing, as she fluctuated back and forth related to what she was doing, and where staff members were and who did what and when. At one point she said she was sitting in the chair in the hallway, and she refused to go to her room as directed by staff. Then that she was sitting on the floor, she refused to get up and almost hit Ms. Coleman, whom she admitted disliking. She said Ms. Coleman and Ms. Simpson each had one of her feet, Ms. Anderson her arms and they picked up her off the floor, and dragged her to her room. She also said Ms. Coleman hit her in her head while in her room, but she could not explain how.

Resident A then reported once they dragged her inside her room, she stood up, pulled Ms. Coleman's hair, cussed, called Ms. Coleman out of her name, and Ms. Coleman pulled her, (Resident A), hair back; and they tussled back and forth. Resident A said she was fighting Ms. Coleman back and Ms. Simpson and Ms. Anderson stepped in to help Ms. Coleman, and then back up was called for. She said at one point the three staff had her on her bed and she couldn't breathe. She indicated twenty minutes later Ms. Coleman came back to her room and said "Oh you are tired now after getting that ass whipping".

When asked, Resident A reported no marks or bruises from the incident described above.

Resident A reported when she left a classroom on January 10, 2014, Ms. Coleman pushed the door on her. Resident A said she was acting up, getting out of her seat, refusing to follow the staff directives, (because she didn't want to be in the class) and Mr. Purnell was called. She indicated when she walked toward the door and left with Mr. Purnell. Ms. Coleman closed the door on her.

Ms. Coleman denied the allegations. She indicated when she was conducting rounds Resident A was discovered out of her room. She said the resident was sitting in a chair across from her room with a blanket, and Resident A said she was going to self-harm with a comb. She said staff (Ms. Anderson and Ms. Simpson) saw the comb; Resident A refused to give it to them, so they talked with Resident A for a long while, in an attempt to persuade her to give them the comb. She said when Resident A stood up Ms. Anderson grabbed for the comb and Resident A "Became irate and verbally abusive," and went to grab at Ms. Anderson, so Resident A was restrained.

Ms. Coleman reported the incident started out as an escort. She stated that a two man grab was performed, and she switched off with Ms. Anderson. (Ms. Coleman described Ms. Anderson as an older woman who was working with one bad arm or had something wrong with one of her arms; and indicated that was why she was initially assisting her). She indicated Ms. Simpson had one of Resident A's arms, and Ms. Anderson the other; and they were physically escorting Resident A to her room. She said no one had Resident A's legs. She indicated after Resident A was in her room, Resident A got really aggressive, verbally threatening; and swung and spit at staff. She said she attempted to do a blindside swoop physical intervention, but it was hard to perform, and Ms. Simpson intervened and assisted her in getting Resident A into the settle position.

Ms. Coleman denied hitting Resident A or pulling the resident's hair. She said when she went to grab Resident A, Resident A grabbed her (Ms. Coleman) hair, but she did not grab Resident A's hair. She indicated the resident was wild, and it took several minutes to calm her down.

When asked if Resident A was dragged to her room, Ms. Coleman went back and forth on indicating whether the resident was dragged. She initially said Ms. Anderson and Ms. Simpson sort of dragged the resident. Then she indicated Ms. Anderson, and Ms. Simpson didn't really drag Resident A, that Ms. Anderson and Ms. Simpson had their arm under the resident's arms and they dragged her, then she corrected herself and said they had her wrist and lifted her up and got her to the room, which was very close to where they were in the hallway. When asked where were Ms. Anderson and Ms. Simpson's hands in relations to the resident's arms, Ms. Coleman indicated Ms. Anderson had both of her hands gripped on one of Resident A's arms (the wrist area) and Ms. Simpson had both of her hands on the other arm of Resident A.

Ms. Coleman also denied closing the classroom door on Resident A. She reported Resident A came to class and was not supposed to be there, causing her to call for a supervisor. When Mr. Purnell arrived to get Resident A, she was trying to argue with another resident. Ms. Coleman reports as Resident A was stepping out of the classroom, she stepped forward and closed the door. She said Resident A had already exited and the door was not closed on Resident A.

Mr. Christopher Purnell reported being called to the class room related to Resident A; and indicated he was already coming to get Resident A because she was to help him. He said when Resident A saw him "She got up as if she was going to walk out anyway," without permission. Ms. Coleman opened the door, and then as he walked out, with Resident A, they closed the door. He said Resident A may have felt like the staff closed the door on her, but they did not. They just closed it after she left.



It needs to be noted that attempts were made to obtain Ms. Anderson and Ms. Simpson's individual statements, but contact was not achievable with the telephone numbers that were available. .

**Reviewed:**

Incident report dated 1/6/2014, completed by Ms. Coleman, signed by Christopher Purnell as supervisor, which indicated:

- While doing PM rounds Resident A expressed upset about being in a room by herself and staff intervened by opening the resident's door and speaking with her.
- Staff observed resident with a comb in her hand, and noticed Resident A was attempting to self-harm.
- Staff quickly intervened, removed the comb and escorted the resident back to her room. The supervisor was informed; and once Resident A was in her room she became verbally aggressive toward staff; and she was able to calm down after talking with the supervisor.
- The incident report's Nurse's follow up section indicated Resident A denied any pain or discomfort; and "No apparent injuries to report".
- No notation as to at what point Resident A left her room, or that she was sitting in a chair in the hallway with a blanket.
- A "no" notation for both with regards to whether "Escort" or "Physical restraint" was used; yet when Ms. Coleman was interviewed, she reported both were used.

Two other incident reports dated 1/10/2014, completed by Paige Henry, and signed by supervisor/Clinical Director, Karen Wickline that indicated:

- Resident A informed Ms. Paige she was physically assaulted by Ms. Coleman during a restraint in the resident's room on 1/6/2014.

**Video camera footage which showed:**

- Resident A sitting in the hallway.
- Ms. Simpson with Resident A.
- Ms. Anderson and Ms. Coleman appearing to talk to Resident A.
- At about 10:40 PM, Ms. Anderson and Ms. Simpson dragged Resident A to her room; each staff had one of Resident A's arms. Ms. Coleman on the scene, but standing in back of them as the incident happened.

<b>APPLICABLE RULE</b>	
<b>R 400.4137(1)</b>	<b>Discipline and behavior management.</b>
	(1) An institution shall establish and follow written policies and procedures regarding discipline and behavior management. Upon request, these shall be available to all residents, their

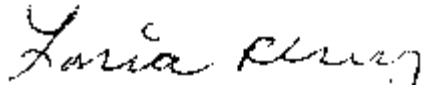
	families and referring agencies. Staff shall receive a copy of these policies and procedures and shall comply with them.
<b>ANALYSIS:</b>	<p>Although Resident A was unclear in her description of the incident, and the allegations against Ms. Coleman was not supported by evidence, the video camera supported the resident's allegation that she was dragged; and that Ms. Simpson and Ms. Anderson failed to use Handle With Care the Behavior Management endorsed by the agency.</p> <p>Per the Director other staff members have been terminated due to failure to use the restraint techniques endorsed by the agency, but improper restraints continue.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	<p>(2) An institution shall prohibit all cruel and severe discipline, including any of the following:</p> <p>(i) Excessive chemical, mechanical, or physical restraint.</p>
<b>ANALYSIS:</b>	The evidence/ video camera footage showed the resident was dragged to her room, and improper and excessive physical management was used.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### **IV. RECOMMENDATION**

Due to the violation outlined in this report and the ones outlined in special investigations 2014C042003, and 2014C0420010, each in and of itself an issue of residents' safety, combined they suggest an additional level of concern requiring the facility's assessment and action. And while it is to the facility's credit that it acted swiftly and terminated the staff involved in each incident, a constant firing of staff as a corrective action plan is not an effective remedy for what may be something more deep-rooted.

Therefore, based on the findings pertaining to these three special investigations modification of the facility's license to a provisional license is recommended; upon receipt of an acceptable corrective action plan.



February 6, 2014

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Lonia Perry  
Licensing Consultant

Date

Approved By:



Linda Tansil  
Area Manager

**February 6, 2014**

Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

February 27, 2014

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2014C0420016  
Detroit Capstone

Dear Mr. Ziglor

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2014C0420016
<b>Complaint Receipt Date:</b>	01/17/2014
<b>Investigation Initiation Date:</b>	01/17/2014
<b>Report Due Date:</b>	03/18/2014
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Resident A alleged that during a restraint, staff, Mr. Booker grabbed his hand and twisted it.

## III. METHODOLOGY

01/17/2014	Special Investigation Intake 2014C0420016
01/17/2014	Special Investigation Initiated - Face to Face Spoke with Director, Pernell Ziglor
01/22/2014	Contact - Face to Face Interviewed Resident A
02/05/2014	Contact - Telephone call made Spoke with Mr. Ziglor
02/06/2014	Contact - Face to Face Spoke with Clinical Director, Karen Wickline
02/07/2014	Contact - Telephone call made Spoke with Youth Specialist, Mr. Harris
02/07/2014	Contact - Telephone call made Spoke with Youth Specialist, Mr. Booker
02/17/2014	Contact- Telephone call made To the agency
02/17/2014	Contact- Telephone call received Spoke with Youth Specialist, Tony Clay
02/17/2014	Inspection Completed BCAL Sub Compliance

### ALLEGATION:

Resident A alleged that during a restraint, staff, Mr. Booker grabbed his hand and twisted it.

### INVESTIGATION:

Resident A reported he got restrained because he refused to leave the group when asked. He said staff should not have put hands on him, and they went after his personal folder with pictures of his family. He said he tried to get his stuff, and Mr. Clay said "you know you can get restrained for trying to come at us" He said he just wanted his stuff. He indicated he was walking on his own, and then Mr. Clay, Mr. Booker and Mr. Harris came and threw him against the wall and put him in the hallway, then BMR (behavior management room) room. Resident A said he was

resisting the restraint, trying to get away, and Mr. Booker was bending his fingers on his right hand. He said Mr. Clay had his legs. He said he asked Mr. Booker to stop bending his fingers and Mr. Booker told him he (Resident A) needed to do what Mr. Booker said; then Mr. Booker squeezed his fingers tighter until he agreed.

Resident A reported Mr. Ziglor came to the BMR room, saw that Mr. Booker was twisting his fingers; and told Mr. Booker what he was doing was not a proper restraint. He said Mr. Ziglor told him to calm down, and told Mr. Booker to leave. He indicated, Ms. Wickline had also “seen what they were doing, but she didn’t do anything”. When asked whether he received any marks or bruises, Resident A denied any, but report his thumb hurt, that he had heard it pop.

Director, Pernell Ziglor reported Mr. Booker did not twist Resident A’s arm or hand but Mr. Booker was not restraining the resident properly. He indicated Mr. Booker grabbed the resident’s hand not arm that Mr. Booker had not hooked into the resident’s arms as required by their physical management procedure Hand With Care. He said Mr. Booker had his hand in the resident’s hand as if Mr. Booker was holding the resident’s hand. He indicated when he advised Mr. Booker that Mr. Booker had the restraint wrong; Mr. Booker asked him (Mr. Ziglor) if he wanted to do this( the restraint). Mr. Ziglor indicated Mr. Booker did not readjust his hand position in the restraint at that time; and he ultimately asked Mr. Booker to leave.

Mr. Ziglor indicated Mr. Booker later reported he (Mr. Booker) grabbed the resident’s hand because his (Mr. Booker) arm got tired. Mr. Ziglor indicated Mr. Booker was sent home the day of the incident; and terminated January 19, 2014, as a result of insubordination pertaining to this incident; and other personnel matters.

Clinic Director, Karen Wickline reported she walked up on Mr. Booker and another staff, whose name she did not know, restraining Resident A. She indicated the two staff each was on one of Resident A’s arm; Resident A’s hand was behind his back. She indicated the restraint was not properly done in that the staff’s arm was supposed to be hooked underneath the resident’s arms, so that the staff’s hand was flat on the resident’s back. She said Mr. Booker had Resident A’s hand bent and Resident A “was screaming you’re hurting my hand”. She told Mr. Booker to fix his hands, to hook into the resident’s arm, but Mr. Booker didn’t do anything differently. She indicated Mr. Booker, did not adhere to her instruction for reasons she surmised may have related to her being new, and Mr. Booker not knowing her role, and or him not respecting her authority. She indicated Resident A was not being deescalated; and he was looking to her for assistance, but nothing changed. So Resident A perceived that she was not intervening on his behalf; and Resident A said “you’re not stopping it”.

Ms. Wickline called for assistance; Mr. Ziglor arrived, and confronted Mr. Booker as the two staff walked Resident A to the BMR room. She affirmed Mr. Ziglor’s reporting that he advised Mr. Booker of the improperness of his hold on the resident; and that Mr. Booker said do you want to do it. She said Mr. Booker did not change what he



was doing, and Mr. Ziglor consequently took over the restraint, and asked Mr. Booker to leave. When asked if the other staff was performing the restraint correctly, Ms. Wickline indicated he was.

Youth Specialist, Ines Harris acknowledged awareness of incident; and reported the resident had refused the therapist and staff's requests for him to leave the group. He indicated he and Mr. Booker attempted to escort resident to the hallway. He said the resident had become upset because he couldn't take his folder; and he made verbal threats. He reported the restraint occurred in the hallway, because Resident A was trying to swing and spit on staff. He said he and Mr. Booker had Resident A up against the wall; that he and Mr. Booker had an arm each. That each had their arm wrapped around Resident A's arm; and his and Mr. Booker's position on the resident was correct. He acknowledged there was a time Ms. Wickline passed through the hallway, she tried to calm Resident A down; but Resident A tried to spit on her. Mr. Harris denied Ms. Wickline said anything about how he or Mr. Booker had Resident A in the restraint. He said Ms. Wickline went back and forth in the hallway; and he and Mr. Booker had the resident in two different areas during the escort; but he never heard her call for assistance, or told Mr. Booker, Mr. Booker had the resident incorrectly in the restraint. He reported once they had Resident A in the BMR room, they held him against the mat (matted wall); Mr. Ziglor arrived, told Mr. Booker, that Mr. Booker had the resident in an improper restraint, and to let the resident go. When asked if Mr. Booker told Mr. Ziglor, did he want to do this, Mr. Harris acknowledged Mr. Booker had, but indicated it was not said negatively. He indicated Mr. Booker said something to the effect Resident A was still hostile and struggling and it was not safe to let him go. He said Mr. Booker did let the resident go; and Mr. Ziglor took over in the restraint.

When asked if Resident A was screaming you're hurting my arm or wrist; Mr. Harris admitted Resident A screamed that. When asked if he loosened his grip on the resident, after the resident indicated such, Mr. Harris said no, because the resident was still struggling. When asked if Mr. Booker loosened his grip, Mr. Harris did not know. He indicated he was not watching Mr. Booker, because he was concentrated on Resident A's head that the resident was struggling, trying to head butt; and he now trying to kick. He asked Mr. Clay to watch the resident's legs, and Mr. Clay pushed Resident A's legs downward when Resident A tried to kick.

Youth Specialist, Stephen Booker recalled the incident and reported it was a two man escort that turned into a two man restraint after the resident got physically aggressive, was kicking and spitting. He said he walked into the situation, which was initially being handled by Mr. Harris and Mr. Clay. He took Mr. Clay's position in the restraint, and Mr. Clay assisted on the resident legs. Mr. Booker denied twisting Resident A's hand or arm, or being accused of such. He reported he was told his restraint of the resident was wrong because he had his hand in the resident's hand. He said Resident A was pinching him so he put his hand into the resident's left hand; but there was no twisting of the resident's arm or anything like that. He indicated at no time did Resident A say his arm, or his arm was being hurt; that

Resident A said something like let me go so I can whip all of you, but the resident used cuss words.

Mr. Booker acknowledged there came a time when Ms. Wickline came upon them restraining Resident A in the hallway. He indicated she was on the scene about three times, but he denied Ms. Wickline ever said anything to him or Resident A. He indicated Resident A asked her if she was going to let them restrain him, but she didn't respond, and Resident A verbally threatened her. Mr. Booker said he then asked Mr. Wickline to step aside so Resident A could not kick or harm her. He saw her leave, but never heard her radio for assistance.

Mr. Booker also acknowledged Mr. Ziglor's arrival when he and Mr. Harris had Resident A in the BMR room. He indicated Mr. Ziglor advised him to let the resident's arm go; and he asked Mr. Ziglor "what would you like me to do with his arm". When asked if he was apprised he was doing the restraint improperly, Mr. Booker indicated Mr. Ziglor told him he was not to have his hand in the resident's hand; and he told Mr. Ziglor the resident was pinching him. He indicated when Mr. Ziglor said to let the resident go, he (Mr. Booker) said something like "then you can come hold him" He told Mr. Ziglor "letting him go wasn't safe" and he asked Mr. Ziglor "if he wanted to take my spot". He indicated he was never told to readjust his position on the resident, because then that would be a one man restraint; which Mr. Harris did take on for a while, but he (Mr. Booker) had to control Resident A's leg because Resident A was kicking, spitting and trying to head buck. He said Mr. Ziglor tried to deescalate Resident A, switched off with Mr. Harris, and told Harris to leave. He and Mr. Ziglor were restraining the resident, and once Resident A was calm for about a minute, Mr. Ziglor asked him (Mr. Booker) to leave out of the resident's view; and he left.

Mr. Booker indicated he was about safety, and he did not think he did the wrong thing. He surmised he was terminated because he told the administrator, no to letting the resident go. He said the facility was reaching, and even helped the resident write the grievance which is never done, is against policy.

Youth Specialist, Tony Clay acknowledged awareness of the incident. He reported he and Mr. Harris tried to deescalate Resident A out of the group. He said Resident A told them no one could touch him, before anyone was touching him. He said Resident A tried to push pass he and Mr. Harris, and Resident A had a folder; and was telling them they could not have it. He said Resident A was known to have weapons, contraband in his folder, and so he grabbed the folder and tossed it aside until they could examine it. He denied threatening the resident or trying to destroy the folder, but he did believe he tossed it outside the group room. He said the resident was restrained because he kept trying to push pass staff, so he and Mr. Harris had the resident in a two man escort. Mr. Clay had one arm and Mr. Harris the other; and when Mr. Booker came to assist, he switched off with Mr. Booker, but he assisted on the resident's legs. He indicated Resident A was cussing, spitting

and kept kicking and wrapping his legs around Mr. Harris. He said the resident was trying to kick Mr. Booker.

Mr. Clay indicated once the resident was transported to the BMR room, Mr. Ziglor told Mr. Booker his (Mr. Booker) hands were wrong in the restraint. Mr. Clay indicated from what he could see Mr. Booker had to resident ok. He said Mr. Booker was holding the resident's hand/wrist up against the room's matt because the resident was fighting and trying to get out of the restraint. He said Mr. Ziglor told Mr. Booker to let the resident go, but Mr. Booker's goal was to get the kid to safety, and Mr. Booker told Mr. Ziglor he couldn't let the resident go because the resident was still fighting. Mr. Clay said he did not believe the restraint was "dirty". When this Consultant apprised Mr. Clay that the allegation was not that the restraint was dirty, but improper, per their Handle with Care protocol, Mr. Clay indicated "they had his arm hooked, we did what we were trained to do".

Reviewed Incident report dated 1/16/2014, completed by Mr. Ziglor that indicated:

- Mr. Booker was observed improperly handling Resident A, by holding his hand during the restraint. That Mr. Ziglor redirected the staff by telling him to let the resident's hand go and "hook into his arm".
- That after the resident was deescalated he stated he resisted the restraint and started to kick Mr. Booker's foot, who his twisted hand. That every time he "kicked him he would twist my hand". That Resident A "specifically stated Mr. Booker twisted his hand/arm."
- That Resident A and Mr. Ziglor completed a grievance form, Quality manager and BCAL notified.
- Youth seen by nurse. and no pain or discomfort reported

Grievance from Resident A which indicated an allegation that

- Mr. Booker grabbed his hand and twisted and bended his hand when he would step of Mr. Booker foot.

Grievance Policy that indicated:

- "If the resident needs assistance in completing the grievance form, a DBI-CA staff member shall provide assistance."

APPLICABLE RULE	
R 400.4137	Discipline and behavior management.
	(1)An institution shall establish and follow written policies and procedures regarding discipline and behavior management. Upon request, these shall be available to all residents, their families, and referring agencies. Staff shall receive a copy of these policies and procedures and shall comply with them.

<b>ANALYSIS:</b>	<p>Each direct care staff reviewed denied that Mr. Booker's handling of the resident was improper; however, each of the two administrators reviewed reported how Mr. Booker held the resident was not correct, and that Mr. Booker had his hand in the resident's hand, not hooked into the resident's arms as Handle With Care instructs. Mr. Booker also indicated at one point he had his hand in the resident's hand.</p> <p>The facility did not adhere to its policy.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	<p>(2) An institution shall prohibit all cruel and severe discipline, including any of the following:</p> <p>(a) Any type of severe physical discipline inflicted in any manner.</p>
<b>ANALYSIS:</b>	The evidence showed the resident's hand and arms were held during the restraint, and that he screamed his arm or wrist was being hurt. However, the evidence is not clear as to whether severe physical discipline was inflicted. The resident had no marks, bruises or reported discomforts.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4109</b>	<b>Program statement.</b>
	<p>(1)An institution shall have a current written program statement which specifically addresses all of the following:</p> <p>(c)Policies and procedures pertaining to admission, care, and discharge of residents.</p>
<b>ANALYSIS:</b>	The evidence does not support allegation as implied by Mr. Booker. The facility's policy allows a staff to assist a resident with completion of his or her grievance form.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

A corrective action plan is required due to the violation outlined in this report.

Modification of the facility's license to a provisional license was recommended earlier this month based on violations outlined in special investigations 2014C042003, 2014C0420010, and 2014C0420011, due to issues of residents' safety, and concerns requiring the facility's assessment and action. And while it was to the facility's credit that it acted swiftly and terminated the staff involved in each incident, a constant firing of staff as a corrective action plan is not an effective remedy for what may be something more deep-rooted.

The recommendation for the modification of the facility's license to a provisional license, upon receipt of an acceptable corrective action plan is continued. .

February 26, 2014

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Lonia Perry  
Licensing Consultant

Date

Approved By:

**February 27, 2014**

Linda Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

March 13, 2014

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2014C0420017  
Detroit Capstone

Dear Mr. Ziglor

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2014C0420017
<b>Complaint Receipt Date:</b>	01/20/2014
<b>Investigation Initiation Date:</b>	01/22/2014
<b>Report Due Date:</b>	03/21/2014
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE



## II. ALLEGATION(S)

Resident A was punched by another resident and had to be taken to the hospital for possible fracture to his nose.

## III. METHODOLOGY

01/20/2014	Special Investigation Intake 2014C0420017
01/22/2014	Special Investigation Initiated - Face to Face Spoke with Director, received incident report, and spoke with Resident A and Resident B
01/27/2014	Contact - Telephone call made spoke with Mr. Spoke with Mr. Ziglor RE view of video footage
01/31/2014	Contact - Telephone call made Spoke with Supervisor, K Powell
02/06/2014	Contact - Face to Face Spoke with Mr. Ziglor , interviewed Resident A, Resident C and Resident D
02/07/2014	Contact - Telephone call made Spoke with Youth Specialist, Brandon Childs
02/07/2014	Contact - Telephone call made Left message for Supervisor, Turner Marshall
02/11/2014	Contact - Telephone call received Spoke with Supervisor, Turner Marshall
02/28/2014	Inspection Completed- BCAL Sub. Compliance

### ALLEGATION:

Resident A was punched by another resident and had to be taken to the hospital for possible fracture to his nose.

### INVESTIGATION:

Director, Pernell Ziglor reported Resident A was assaulted by Resident B on January 19, 2014; and Resident A was sent to the emergency room. Resident A was diagnosed with a nose contusion. Mr. Ziglor indicated the two residents did not like each other very much; and the incident was a random act. He indicated the incident occurred during the dinner time and that group has a 1:5 staff-to-resident ratio.

Resident A, Resident C and Resident D all indicated the incident occurred at dinner time, in the lunch room as well as; and that two staff, Mr. Child and Mr. Marshall (per two of the residents) were the only staff in the room. All three residents reported one staff sat in the area with the residents, and the other staff was in the kitchen/ food area, getting the food. All three residents indicated Resident B punched Resident A in the nose, with a closed fist; and Resident A's nose bled. Each also indicated the fight happened when, Resident B punched Resident A after Resident A took or would not give back or would not stop touching a folder or picture that belonged to Resident B.

Resident A indicated the incident occurred on January 20, 2014, that he and Resident B sat across from one another at the a dining table; and Resident B showed him something in Resident B's folder. He said he grabbed a letter, not a picture that was in the folder, and Resident B said "I don't play that and Resident B stood up, so he did too. Initially Resident A said they were playing around; and then Resident B just punched him in the nose with a closed fist. When this Consultant spoke with him the second time he said cuss words were exchanged, before Resident B punched him.

Resident A indicated after he was punched, his nose was bleeding; he went after Resident B and staff restraint him, but not Resident B. He reported the staff did not act to stop the incident from happening. Although he indicated Mr. Childs sat in the corner in grabbing distance of them, and that Mr. Childs grabbed him; he said Mr. Childs didn't do anything. He said Mr. Marshall was in the kitchen, about six feet away, and could not get to him in time.

Resident A acknowledged receiving medical treatment and that there was contact with his mother.

Resident B denied the incident; and refused to be interviewed.

Resident C reported Resident A and Resident B were playing around, Resident A was looking in Resident B's folder, which contained a picture of Resident B's grandmother. Resident B got his folder back, but Resident A had a picture of Resident B's grandmother, and was teasing Resident B. That Resident A gave the picture back, but shortly after that words were exchanged, Resident A told Resident B "F" your grandmother, Resident A stood up, and Resident B, who was already standing, punched Resident A in the nose. He said one staff (he could not recall the two staff's names) was seated in the area with all the residents; and the other staff was across from them in the eating area where the food was located. He said the staff that sat with the residents, grabbed Resident A because Resident A was coming after Resident B; and was making threats to kill Resident B. He said Resident B was not going after Resident A, Resident B was just saying "I told him I didn't play that, that he was touching my grandmother's picture".

Resident C said neither of the two staff knew that Resident A and Resident B were arguing because the group was loud.

Resident D reported being a resident in Group A. He said Resident B and Resident A were arguing because Resident B was touching Resident A's folder. He said Resident A was shocked by Resident B punching him in the nose. He said Mr. Childs did not know what was going on because Resident A and Resident B were quietly arguing. He said Mr. Childs had told Resident B and Resident A to sit down, but Resident B was "quick like Floyd Merriweather" and Resident B punched Resident A. Resident D said "soon as he threw the punch Mr. Child was right there"; he grabbed Resident A. He said Resident A tried to react but Mr. Childs and Mr. Marshall took Resident A out of the lunch room; and Ms. Powell who was walking pass, helped Resident A get to his room.

Resident A, Resident C and Resident D all reported there were more than ten residents in the dining room, at the time of the incident. Resident A said there were more than eight residents in another group and six or seven in his group (Group B). He indicated normally there is four staff, Mr. Childs, Mr. Flynn, Mr. Avery and Mr. Montgomery that works with the whole groups. He said Mr. Childs and Mr. Flynn typically worked his groups, but Mr. Flynn was in another building; and either Mr. Avery or Mr. Montgomery was in the dining area. Resident C reported there were six residents from his group (Group B); and nine to twelve residents in the other group (Group A). He said the facility was short staff that day. Resident D said there were twelve to thirteen residents in the lunch room; that only about half of Group B was there, and nine were in his group (Group A).

Supervisor, Keyshuan Powell, reported she was not in the lunch room or on duty at the time. She happened to be on-site/be passing by, and saw Mr. Childs with Resident A. She assisted because Resident A was trying to get back in to assault Resident B.

Youth Specialist, Brandon Childs, acknowledged awareness of the incident; and being one of two staff working in the lunch room at the time. He said the two residents were talking and playing, they stood up, he instructed them to sit down, and then Resident B swung on Resident A. He said the incident happen so quickly; and when Resident A grabbed his nose, and then ran after Resident B; he grabbed Resident A before Resident A could get Resident B. He said Mr. Marshall grabbed Resident B.

Mr. Childs said he sat at the table with Group B, sort of at the head of that table; and Resident A and Resident B were at this same table sitting one seat across from each other. Mr. Childs was not sure where Mr. Marshall was at the time of the incident, but when asked if Mr. Marshall was in the kitchen, Mr. Childs thought he may have been.

Supervisor, Marshall Turner, indicated Resident B basically got into an altercation with Resident A; and staff intervened. He said Resident A snatched something from Resident B; Resident B swung on Resident A; and Mr. Child's grabbed Resident A before Resident A could get around the table. Mr. Marshall was in the kitchen, getting food for the residents; and rushed out and grabbed Resident B. He said he was going to restrain Resident B, but then did not need to as Resident B was calm; and Resident B sat down and said he was not going to do anything. Resident A was escorted out of the lunch room by Mr. Childs.

When asked how many residents were in the room, Mr. Childs reported he was in charge of Group B which had "six or seven kids"; and Mr. Marshall was with the other group that had "six or seven kids". He said they "wanted to keep it small to be in ratio". Mr. Marshall reported being unsure of if there was one group or two groups in the room; but knew there were not two full groups in the lunch room. He said there was "about ten" residents. When asked if there was about ten or ten, Mr. Marshall indicated there were ten; that they were within staff-to-resident ratio.

Reviewed:

- Incident reports that documented Resident B's assault of Resident A.
- Nurse's follow up section to the incident reports that showed the nurses assessment of the two residents; and Resident A was sent to the emergency room for treatment.
- Copy of email from the facility that indicated Resident A diagnosed with contusion to the nose/possible fracture; and medical follow up.
- Staffing Plan Policy; which mandated a 1:5 staff-to-resident ratio for the Matrix group.
- It is noteworthy that video footage of the incident was reported accidentally deleted.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(2) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS:</b>	The evidence showed the incident happened very quickly, staff intervened promptly, and terminated the incident/secured each resident.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4109</b>	
	(1) An institution shall have a current written program statement which specifically addressed all of the following: (c) Policies and procedures pertaining to admission, care, and discharge of residents.
<b>ANALYSIS:</b>	<p>The evidence showed there was two staff with more than ten residents in the room at the time of the incident; and the facility was not in compliance with staffing policy that mandates a 1:5 staff-to- resident ratio for that program:</p> <p>Two of the staff members interviewed, and three of the residents interviewed all reported two staff were in the lunch room at the time of the incident. The three reported residents and one of the staff mentioned all reported there were more than five residents in each of the two groups that were in the lunch room.</p> <p>Given how the incident occurred it cannot be determined whether the decreased number of staff at the time, impacted on incident's occurrence</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

The continued recommendation for a modification of the facility's license to a provisional license, in connection to special investigations 2014C0420003, 2014C04200010, and 2014C0420011 remains.

March 6, 2014

\_\_\_\_\_  
Lonia Perry Date  
Licensing Consultant

Approved By:

March 13, 2014

\_\_\_\_\_  
Linda Tansil Date  
Area Manager



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

April 1, 2014

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2014C0420022  
Detroit Capstone

Dear Mr. Ziglor:

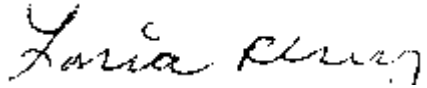
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

A handwritten signature in cursive script, appearing to read "Lonia Perry".

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2014C0420022
<b>Complaint Receipt Date:</b>	02/27/2014
<b>Investigation Initiation Date:</b>	02/27/2014
<b>Report Due Date:</b>	04/28/2014
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE



## II. ALLEGATION(S)

Resident A reported staff Tony Clay punched him in the face, shoved him, and threw him around the round. Due to the incident, Resident A has a laceration to lip and a swollen left eye.

## III. METHODOLOGY

02/27/2014	Special Investigation Intake 2014C0420022
02/27/2014	Special Investigation Initiated - On Site Spoke with Director, Pernell Ziglor and Clinical Director, Karen Wickline
02/27/2014	Contact - Document Received Incident report, resident statement, Nurse Case Note, medical documents
02/27/2014	Contact - Face to Face Interviewed Resident A and Resident B
02/27/2014	Contact- Telephone call made Spoke with Mr. Ziglor
02/28/2014	Contact- Document Sent Email to DHS Worker
03/03/2014	Contact- Telephone call received Spoke with DHS Worker
03/03/2014	Contact-face-to-face Spoke with, Clinical Director, Karen Wickline, Director, Pernell Ziglor, and Resident A, Interviewed Resident C, Resident D, Resident E, Staff, Alicia Yancey, Vicanca Allison, Patricia Johnson, Brian Serafino, and Charter School Teacher, Timothy Johnson
03/03/2014	Contact- Telephone call made Left message for Tony Clay
03/04/2014	Inspection Completed- Sub Compliance

**ALLEGATION:**

Resident A reported staff Tony Clay punched him in the face, shoved him, and threw him around the room. Due to the incident, Resident A has a laceration to lip and a swollen left eye.

**INVESTIGATION:**

This Consultant and the DHS Worker, spoke with Clinical Director, Pernell Ziglor, Clinical Director, Karen Wickline ; and interviewed Resident A and Resident B on February 27, 2014. Ms. Wickline, Mr. Ziglor, and Resident A were re-spoken with on March 3, 2013; and Resident C, Resident D, Resident E, Supervisor, Alicia Yancey, Capstone Academy Charter School Principal/facility staff, Brian Serafino, Capstone Academy Teacher, Timothy Johnson, and Youth Specialists, Vicanca Allison, and Patricia Johnson were interviewed, by this Consultant.

Those interviewed reported the incident occurred on the morning of February 26, 2014 in the English classroom; and all with the exception, of Resident D, who denied seeing anything, and Ms. Yancey and Mr. Serafino, who were not present at the time of the incident, indicated Mr. Clay attacked and or was involved in a physical altercation with Resident A.

Mr. Ziglor and Ms. Wickline reported becoming aware of the incident sometime after it had occurred; and each spoke with Mr. Clay prior to review of their camera footage. Both reported Mr. Clay was in the classroom with Resident A, other residents, and the English teacher. Ms. Wickline thought there were a “whole bunch of children in the classroom at the time of the incident; but Mr. Ziglor reported there were only three or four; as one other resident(alleged victim in Special investigation(2014C0420025) had been removed from the class, by Ms. Richardson due to his behavior. Mr. Ziglor reported Resident A was typically a difficult resident to engage with.

Mr. Ziglor reported per review of the camera footage: Resident A sat on a desk and was kicking the chair, and Mr. Clay tried to redirect the resident. Resident A got agitated, pushed Mr. Clay’s arm; and Resident A jumped off the desk and pushed Mr. Clay again. That Mr. Clay “goes in” and grabbed Resident A, but that it wasn’t clear from the tape whether Mr. Clay hit the resident at that point. But then Resident A was on the floor and Mr. Clay punched Resident A four or five times. He indicated staff Ms. Jones, Ms. Allison; and Mr. Golden, who escorted Resident A out of, came into the room and broke up the fight.

Mr. Ziglor indicated he spoke with Mr. Clay, while Mr. Clay was completing the incident report and Mr. Clay reported Resident A was being very difficult; and at one point Mr. Clay stated that Resident A “he is the Devil”; in terms of the resident behavior’s, him acting out. Mr. Ziglor also spoke with staff Ms. Allison, who was one of the first person’s on the scene, at the time of the incident. He indicated Ms. Allison reported Mr. Clay was not restraining the resident right, and she ultimately indicated Mr. Clay “loss it” on the kid.

When asked if Mr. Clay sought assistance related to Resident A prior to the attack, Mr. Ziglor indicated Mr. Clay did not have a radio; but that at one point (in the video) Mr. Clay stuck his head out of the classroom's door prior to the actual altercation.

Ms. Wickline reported Mr. Clay came to her at 10AM, on February 26, 2014; and he reported there was an incident with Resident A in the English class. She indicated Mr. Clay reported Resident A had been disrespectful, attempted to destroy property by kicking and pushing the book shelf, etc; and that he tried to deescalate Resident A. That he tried to put Resident A into a restraint, but it was not working, that there was no Primary Restraint Technique (PRT) for the situation. Mr. Clay reported he thought he might have hit Resident A; and flipped Resident A over a desk (Ms. Wickline indicated per her later view of the video footage, it did not show Mr. Clay flipped the resident over a desk) . Ms. Wickline said Mr. Clay reported the incident happened so fast, and he stated multiple times that "I wasn't doing the restraint right". That he said he had stuck his head out the classroom door to ask for help. When asked if Mr. Clay had a radio, Ms. Wickline reported she didn't think he had one, or it may not have been working. He indicated every group is required to have a radio. Mr. Ziglor affirmed that all staff groups are required to have a radio.

Ms. Wickline reported asking Mr. Clay if he was ok, and she instructed him not to return to the floor, to go complete the paper work related to the incident. When asked why she didn't send Mr. Clay home at that time, Ms. Wickline indicated she was not sure she had the authority to do so. When this Consultant indicated that in other cases staff had been sent home prior to all paper work/ incident reports data being completed; Mr. interjected the protocol was to get the staff to complete the paper work, that in a past incident that the Consultant may be recalling, that staff was sent home without having that staff to completed the incident report or write an statement because the supervisor had witness the incident. Nonetheless, Mr. Ziglor and Ms. Wickline reported Mr. Clay never completed the entire paper work.

It is noteworthy that Mr. Clay was involved in an incident pertaining to another resident a couple of hours later, (Special investigation 2014C0420025, that is underway). Mr. Ziglor, as well as, Ms. Wickline was unsure how Mr. Clay ended up back on the floor; and Mr. Ziglor reported Mr. Clay and female staff, Ms. Richardson walked off the job during the incident- and reported they quit.

When Ms. Wickline was asked whether she asked Mr. Clay if Resident A was ok, she indicated knowing, at that point, that Resident A was not. She indicated prior to Mr. Clay coming to talk to her; she had seen Resident A in the hall being attended to by the nurse. She indicated at that time Resident A's lip was bleeding and his eye looked swollen. She said when Mr. Clay relayed to her what he had done, he made the statement, "you saw his face", referring to Resident A's.

Mr. Ziglor indicated Mr. Clay, was a nine year plus employee, with no past major personnel concerns, who had "always tried to talk kids down; but yesterday he loss

it. He indicated Mr. Clay was terminated effective February 26, 2014; due more specifically to the incident with Resident A.

When inquiry was made as to whether the police were called about this incident, Mr. Ziglor indicated, they had not, that legal had advised that would occur via protective services. Following an advisement from this Consultant, that the police report should be made, Mr. Ziglor indicated he tried to report the incident, but the police refused it. He indicated the police explained since the resident was a minor in a residential treatment facility, the facility's report would be considered third party. Reportedly the report had to be provided by the resident's guardian.

Resident A(14) reported he got mad because he was bored in his English classroom, so he started tearing tape off the window. He said Mr. Clay told him to sit down twice, but he wouldn't. Resident A said he was sitting on his desk, then sort of standing near or leaning on the cabinet and also his desk. He indicated when he would not sit down Mr. Clay slapped his wrist twice, then punched him several times, once in the eye and once in his lip. Resident A denied pushing or hitting Mr. Clay. He indicated after he was punched, Mr. Clay threw him across the room; he landed on his stomach atop a desk, with his face lending out into the seat; and Mr. Clay kicked him in the face a couple of times. When asked if Mr. Clay had anything on his hands when Mr. Clay hit him, Resident A was not sure. He said he had seen Mr. Clay put/wrap a key ring on his (Mr. Clay) "two fingers", the "middle and ring finger of his right hand" sometime earlier in class, but he did not know if Mr. Clay hit him while Mr. Clay had the key ring on.

Resident A indicated a lot of staff arrived and someone grabbed Mr. Clay, and staff, Mr. Golden grabbed him. Resident A indicated at the time of the incident, teacher, Mr. Johnson, Resident B, Resident C, Resident D, and Resident E were in the classroom. After the incident, Resident A said he was seen by the nurse, and then sent to the emergency room. It is noteworthy, that at the time of his interview on February 27, 2014, Resident A presented with a dark swollen left eye and minor irritation to his lip, which he said had been worst.

Resident B, Resident C, Resident D, and Resident E residents in the Horizon group all admitted being in the English classroom at the time of the incident. All with the exception of Resident D, who refused to answer questions, indicated Mr. Clay called, on his radio, for assistance prior to the incident; and no one came.

Resident B (15) acknowledged that the other four named residents, and teacher, Mr. Johnson were present during the incident. Resident B reported Mr. Clay told Resident A five times to put his feet down off the cabinet, and Resident A wouldn't. That Mr. Clay called the supervisor on the radio two times, but the supervisor did not come; and about five minutes later, Mr. Clay wrapped a metal object, (described as some sort of medium side key chain/ring holder—he drew a picture) around his fist/knuckles and Mr. Clay hit Resident A with a closed fist several times. He said Mr.

Clay also kicked Resident A three or four times. He said the teacher, Mr. Johnson “didn’t do anything, he just stood and watched”.

Resident C (17) reported Resident A swung on Mr. Clay and “Mr. Clay handled his business”, that Mr. Clay swung and hit Resident A to Resident A’s body more than one time. Resident C was not sure where precisely Mr. Clay’s punches landed, how many times Mr. Clay hit Resident A, or whether Mr. Clay hit the resident with his fist. He was also not sure if the staff had anything on his hand when Resident A was hit. Resident C he did not see blood on Mr. Clay, Resident A, or the floor. Resident C indicated he was in the corner of the room; and he heard Mr. Clay, and he got up. He said prior to Mr. Clay and Resident A “going into it”. He said Mr. Clay had called for assistance two to three times, but no one came.

Resident D (15) initially denied being present in the classroom or seeing what happened. After he was informed there was video that showed he was present; Resident D acknowledged being present; but denied seeing anything that happened. He refused to answer questions. It is noteworthy that per review of the video camera footage, Resident D was seen sort of in the mix, in that it appeared as if he tried to break off the incident between Mr. Clay and Resident A.

Resident E (16) reported he did not see much due to a problem with his eyes (he had broken his glasses). He indicated he heard Mr. Clay tell Resident A to “stop”, then “stop touching that”. He indicated at some point he heard a noise that sounded like someone falling against stuff; and after he turned around he saw Resident A on the ground. Resident E was not sure how Resident A ended up on floor, he did not see Mr. Clay ball up his fist, but indicated the other residents said Mr. Clay did. Resident E reported Mr. Clay was not near Resident A after Resident A was on the floor; and he could not see Mr. Clay hands. When asked if Mr. Clay called for assistance prior to him (Resident E) hearing the commotion, Resident E reported Mr. Clay called someone to tell her to come get Resident A out of the classroom, but “they didn’t come”.

When asked what did Resident A do prior to Mr. Clay hitting Resident A, Resident B reported Resident A was pulling paper off the wall; and Resident A pushed Mr. Clay at least three times. He indicated it was when Resident A pushed Mr. Clay that last time, that Mr. Clay attacked Resident A. Resident B reported Resident A’s, was bleeding, that Mr. Clay busted Resident A’s lip, eye and nose, that all three were bleeding. Resident C indicated Resident A “was tripping”, that Resident A was messing with tape on the wall, and Resident A “was getting mad”. Resident E reported Resident A said no, don’t touch me” and no”. He did not see exactly what Resident A did.

When asked what if anything did Mr. Clay say when he was hitting Resident A Resident A said Mr. Clay said he was” tired of this job, am getting sick of this job.” Resident B indicated Mr. Clay said “I’ll loss my job, I don’t care”. Resident C

indicated neither Mr. Clay nor Resident A said anything; and Resident E didn't know what else was said.

Alicia Yancey, Supervisor on shift the morning of the incident, did not witness the incident. She arrived on the scene afterward. She reported that prior to the incident, Mr. Clay radioed her twice; and the calls were a few minutes apart. Mr. Clay asked her to come to the English classroom to talk with Resident A. She indicated each time she told Mr. Clay she would when she got a moment, that she was dealing with a situation in the Gym. Each time she asked Mr. Clay if he could "stand by", and Mr. Clay said ok. Ms. Yancey said Mr. Clay never indicated it was an emergency, nor said what was going on.

Ms. Yancey estimated that about eight to ten minutes after the last call from Mr. Clay, the OCC (Operation Control Coordinator) radioed for all staff assistance in the English classroom; and when she arrived there "nothing was there". She said Mr. Clay was gone, and Mr. Golden was in the hallway talking with Resident A. When asked if whether in hindsight Mr. Clay sounded, urgent, excited or anxious when he radioed her, Ms. Yancey was not sure. She said there was a lot going on at the time.

Ms. Yancey reported speaking with Mr. Clay, after he handed her the incident report. She asked him what happened, Mr. Clay reported Resident A pushed him, and jumped off the table with his (Resident A) fist balled. When she asked Mr. Clay what he did, Mr. Clay replied, "Ms. Yancey I really don't know". She indicated Mr. Clay appeared calm at that time; and he indicated he was about to leave.

Ms. Yancey did not make excuses for what Mr. Clay may have done, but wanted it known that Resident A is a very impulsive and aggressive youth, who has attacked and bitten staff, that he bit a staff just three week prior.

Youth Specialist, Vicanca, Allison reported her classroom was across the hall from Mr. Clay's; and that about five minutes before the incident, he heard Mr. Clay call the supervisor at least two times for someone to come get the resident from the classroom. She said before she entered the classroom she overheard and saw a portion of the exchange between Resident A and Mr. Clay. She heard Mr. Clay say something about stop tearing stuff off the window; and when she looked Resident A appeared to be pushing Mr. Clay as Mr. Clay walked back upon Resident A. She said Resident A pushed Mr. Clay again, and "they were in the mix of it" that desks were moving, because Mr. Clay and Resident A pumped up against them; and a desk may have went to the floor.

Ms. Allison indicated when she walked into the classroom it appeared as 'if two grown people were in a hug', that Mr. Clay and Resident A were facing each other and each had hands on or around the other. She said at one point it looked as if Mr. Clay was trying to gain control of Resident A. She could not recall if Mr. Clay or Resident A were talking; and that soon after, the two were moving around, tussling and they ended up on a wall. She said both of them fell to the floor; and when



Resident A fell, Mr. Clay fell on Resident A. That as Mr. Clay pulled himself up, Resident A may have been holding on to Mr. Clay, and Mr. Clay kicked Resident A. Ms. Allison was not sure where the kick landed. She said everything happened so quickly, a matter of seconds from when it seems as if two were hugging, to the tussle and to when the two went to the floor. She said she tried to figure out what to do/how to assist, then Mr. Clay walked out and a staff escorted Resident A out. She said Ms. Jones came on the scene after Mr. Clay got off the floor.

When asked if she told someone that Mr. Clay lost it, Ms. Allison admitted she had. That she said to Ms. Yancey, after Ms. Yancey inquired what happened, "it seemed like he lost it". She indicated she said that because Mr. Clay was mad, that he was frowned up, he was not his calm, laid back self; and when he got up he kicked, stormed off, and yelled "I'm sick of this job".

Teacher, Timothy Johnson was interviewed in the presence of Edtec Central VP of Operations & Government Relations, Barbara J. Criqui (for the Charter school) and the Charter School Principal, Brian Serafino. Mr. Johnson reported having worked at this facility since September 2014. He acknowledged being present during the time of the incident. He was particular and technically descriptive in his account of what occurred between Mr. Clay and Resident A.

Mr. Johnson reported Resident A sat on a desk to the left of the door, upon entering the class; and Mr. Clay sat on the right side of the door. He indicated at one point he reminded Resident A to sit in, not on the desk, and Mr. Clay reinforced that instruction to Resident A. After a few minutes Resident A sat in the seat, and then Resident A began to pull paper off the window. He advised Resident A not to do that and Mr. Clay reinforced the instruction; but Resident A continued pulling the paper, and Mr. Clay continued telling Resident A to stop. That that type of exchange went on for a few minutes, and Mr. Johnson proceeded with the lesson, while reportedly indicating out loud that it was ok, that Resident A's actions with the paper on the window was not a big deal. Mr. Johnson indicated that after a while Mr. Clay stood up, stood immediately in front of the resident and near the door. That Mr. Clay closed the door shut, which had been slightly ajar prior. That Resident A continued to pull paper off the window, and Mr. Clay told him "you better stop, or you need to stop" but Resident A continued his behavior and replied to Mr. Clay "what are you going to do about it". Then Mr. Clay shoved Resident A, two or three times by using his left hand on Resident A's left shoulder. When asked if the shoves were gently touches, Mr. Johnson reported they were forceful blows with an open hand.

Mr. Johnson indicated by now, meaning at a point in the incident, the "other four or five residents" were noticing what was going on with Resident A and Mr. Clay, so he tried to redirect them/to proceed with the lesson. He reported Mr. Clay then gave Resident A a two-handed shove with open palms in the chest, and Resident A grabbed, blocked or tried to push Mr. Clay's arm to the side. Mr. Clay then grabbed Resident A in the chest, using Resident A's jumper, he pulled Resident A up out of the desk, pulled Resident A toward him; and Mr. Clay struck Resident A three or

four times with his right fist to Resident A's left side. Mr. Johnson said Resident A was trying to break free, was fraying and moving backward under Mr. Clay's influence and power. Mr. Johnson did not perceive Mr. Clay and Resident A to be in any type or hug position. He said Mr. Clay backed Resident A into a desk. He said at that point Mr. Clay lost his Walkie-Talkie, it fell to the floor. Mr. Johnson reported he went to the door to get assistance, at which time, Ms. Washington (he believed that to be the staff's name) came through the door and someone else was behind her. Mr. Johnson indicated Mr. Clay never called for assistance, nor asked him to call for assistance. He indicated from the point Mr. Clay pulled Resident A from the desk to the end of the attack, the incident lasted about two minutes.

When asked why didn't he use the classroom telephone, and or the radio to call for assistance, he indicated he thought it would be quicker to get assistance; and that why he went to the door. He said the telephone call would have gone upstairs, (Mr. Ziglor reported that would have been to their OCC room); and then there would be a wait for someone to come down. He indicated he did not find Mr. Clay's radio until the incident was done.

Mr. Johnson indicated Mr. Clay never threw Resident A onto the desk, nor did he recall Resident A falling to the ground at any point. He never saw Resident A on ground nor saw Mr. Clay kick Resident A. He reported Resident A never pushed Mr. Clay prior to Mr. Clay putting hands on Resident A.

Youth Specialist Patricia Jones reported she arrived at the classroom behind Ms. Allison as the two had been in the same classroom across the hall. She did not know Mr. Clay needed assistance until she heard a rumpling, and one of her classroom residents said they are fighting over there. When Ms. Johnson entered the classroom she thought two residents were fighting. She reported she instinctually performed a blind-side-swoop physical management technique, and physically managed the person whose back was to her. After he grabbed the person she realized it was Mr. Clay; and she walked him out. She reported being sure, Mr. Clay had called for assistance, but she did not recall seeing his radio. She questioned why the teacher had not helped by at least calling for assistance.

When asked if Resident A received any injury, and was there blood seen, Ms. Allison reported noticing blood in the middle of the floor, after everyone was gone. She indicated once Resident A got up and walked out, she noticed his nose was bleeding. At that time she did not notice any other injury to the resident; but when she "saw him the next day his eye was puffy, kind of swollen". She was not sure if Mr. Clay received an injury. Mr. Johnson reported observing that Resident A had blood to his left eye/head area. Mr. Johnson did not notice if Resident A's nose was bleeding. Yet, after the room was cleared, Mr. Johnson indicated he saw several different sized bloods dropping on the floor. Ms. Jones did not recall the scene; she said she was concentrating on getting the two people off of one another.



When asked if a key chain or ring was observed on Mr. Clay's hand during the incident, Ms. Allison did not see one on Mr. Clay's hand, Mr. Johnson reported he thought Mr. Clay had taken the keys out of his pocket, but he did not see anything shiny on Mr. Clay's finger/hands/knuckle, "not even a ring". Mr. Johnson said he just saw a closed fist, He said at the end Mr. Clay threw his keys across the room and said "I'm done", and walked out the door. Ms. Jones could not recall if Ms. Clay had keys.

#### Reviewed

Incident report dated 2/26/14, 8:30AM that incident:

- The incident report was completed by Mr. T. Clay.
- During English class Resident A became disruptive causing destruction to property; staff directed the resident to discontinue the negative behavior. Resident A refused, staff redirected Resident A again, and Resident A pushed staff and attempted to assault him with a closed fist.
- Resident A was physically managed and escorted to his room; nurse and supervisor notified.
- A Nurse Follow up section that indicated Resident A had a "small scratch on left eye, small scratch on upper lip". Resident A was sent to the emergency room, had no complaint of pain, and complained of blurriness. X-ray was ordered, and follow up with doctor.

Written statement from Resident A dated 2/26/14 that indicated:

- He got bored, his staff told him to sit down, he said no; and then staff came up to him and started punching him in the face. Then staff pushed him to the desk.
- He( Resident A) bust hi lip on the desk.

Two Client Case Notes both by Nurse Smoot that indicated:

- One dated 2/27/14, that indicated during the am shift on 2/26/14 Resident A was physically assaulted. Upon assessment the writer noted swelling and a small scratch under the left eye.
- Basis information as noted in the Follow up section of the aforementioned incident report.
- Contact attempted with Resident A's dad.
- A second dated 2/27/14 that Resident A seen at Children's Hospital on 2/26/14 for an injury to the left eye. That "Discharge paperwork gave a diagnosis peri-orbital contusion (bruise near the eye). Eyrthomycin ointment was prescribed for the injury."

DMC Children Hospital Discharge Instruction that indicated:

- The diagnoses and treatment as indicated in the second Client Case Note; and also listed a finding/diagnosis for conjunctivitis.

Facility Medical Offsite Encounter Form that indicated:

- The medical complaint, as "injury to the ® eye"
- Examination findings and diagnosis as Traumatic conjunctivitis

Camera Video Footage that showed:

- Five kids in the classroom along with Mr. Johnson, and staff, identified as Mr. Clay.
- Resident A seated atop a desk, near the door facing a medium size height file cabinet, which Resident A stood up and leaned on with both arms, at one point. The resident's desk was in front of window
- Mr. Clay sat on the opposite side of the door from Resident A; and he got up, paced from and to, area points, the teacher's desk several varied times during the five minute camera footage.
- Mr. Johnson seen in front of the teacher's desk, with a book. He was not seen at any point approaching Resident A, the other residents, nor did he exit nor attempted to exit the classroom. He did at one point, kick a radio aside, that fell to the floor; and he later picked it up.
- Resident A at his desk at one point, appearing to pull paper like item from the window area; and at 9:05AM Mr. Clay appeared to go in front of Resident A, maybe to say something, then he opened the door; veered out into hall, slightly, came back in, and closed the door.
- Mr. Clay was once again in front of Resident A, who had paper held up in his hand. Then it was hard to see actually happened, the video was not very clear, but Mr. Clay's shoulder sort of went back. Mr. Clay tried to retrieve paper from the resident, and this action type went back and forth for a few seconds. At one point Mr. Clay placed his arm on the door and Resident A appeared to reach for the door and Mr. Clay stopped him.
- At 9:06Am Resident A got off the desk, Mr. Clay and he were facing each other; Mr. Clay grabbed him raised him up. Resident A came up, and he and Mr. Clay appeared to tussle for several seconds. They appeared to be fighting; and as they moved across the room to a wall, they moved a desk. During this time Resident A's hand appeared to be wrapped around Mr. Clay's head; and the two appeared intertwined. The two continued moving across the room, and then Resident A appeared to be on a desk and Mr. Clay leaned over/ downward and threw five to six punches to the Resident A's body.
- Prior to the end of the video footage (still within the 9:06 minute time period), Mr. Clay's body appeared to hunch up, as if he was executing a kick; however his feet/legs are not actually seen kicking.
- Resident D appeared to intervene/to try stop the fight a couple of times.
- At amount 9:07 AM other staff enter the room, and intervene with Mr. Clay and Resident A.
- That Mr. Clay attacked and assaulted Resident A

APPLICABLE RULE	
R 400.4137	Discipline and behavior management.
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following:

	(a) Any type of severe physical discipline inflicted in any manner.
<b>ANALYSIS:</b>	The evidence showed Resident A was hit/punched and kicked by Mr. Clay; the incident resulted in Resident A sustaining a busted lip, bloody nose, and scratched and swollen eye. Severe physical discipline was inflicted
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(1) An institution shall establish and follow written policies and procedures regarding discipline and behavior management. Upon request, these shall be available to all residents, their families, and referring agencies. Staff shall receive a copy of these policies and procedures and shall comply with them.
<b>ANALYSIS:</b>	The evidence showed Mr. Clay did not physically manage the resident using proper Handle with Care protocol.  Mr. Clay appeared to man handed the youth; there was a struggle away the room; and the resident was struck several times by Mr. Clay, while the resident was down.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

### **ADDITIONAL FINDINGS**

During the course of the investigation it was discovered the facility was not within staff-to-resident ratio for the Horizon group, at the time of the incident.

Resident A, Resident B and Mr. Johnson indicated more than four residents were in the classroom. The video footage showed five residents in the classroom.

Ms. Jones indicated typically two staff are in a classroom depending on that groups' ratio. The facility's staffing policy mandates a 1:4 staff-to-resident ratio for the Horizon group.

Though Mr. Ziglor indicated the teacher may be counted in the staffing ratio, both he and the Charter School Principal/Staff, Mr. Serafino, indicated the teacher is not an employee of Capstone/Detroit Behavior Institute. Mr. Serafino reported the Charter School teachers are trained in Handle With Care physical management, but only from the standpoint of utilizing it, executing a restraint if he/she was attacked by a resident. Mr. Serafino indicated the teachers, "do not just stand still and do nothing", their role is to get assistance, not put their hands on the kids during a physical incident.

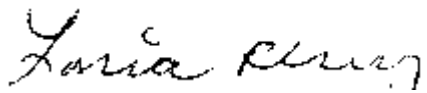
Reviewed:

- The facility's staffing policy.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff to resident ratio.</b>
	(2) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS:</b>	The evidence showed the facility did not follow its staffing ratio policy.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan continuation of the current license status is recommended.

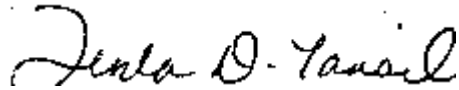


March 5, 2014

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



April 1, 2014

\_\_\_\_\_  
Linda Tansil  
Area Manager

\_\_\_\_\_  
Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

March 27, 2014

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2014C0420023  
Detroit Capstone

Dear Mr. Ziglor:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonja Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2014C0420023
<b>Complaint Receipt Date:</b>	02/25/2014
<b>Investigation Initiation Date:</b>	02/25/2014
<b>Report Due Date:</b>	04/26/2014
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Youth A(14) alleged staff Mr. Belton stepped on his hand, while he was picking up a brush on 2/23/14; and Mr. Belton head locked him, it escalated into a fight that had to be broken up.

On 2/23/14 staff Mr. Brandon Childs pushed Youth A causing Youth A to fall over the toilet and land on his roommate who was lying in bed.

## III. METHODOLOGY

02/25/2014	Special Investigation Intake 2014C0420023
02/25/2014	Special Investigation Initiated - On Site Spoke with Director
02/25/2014	Contact - Document Sent Email to DHS Worker
02/27/2014	Contact - Face to Face Interviewed Youth A, Youth B, and Youth Specialist, Jazmon Belton, Deshanique Beaver and Patricia Jones
03/06/2014	Contact Face to Face Spoke with Mr. Edgar Jones
03/06/2014	Comment- Exit

### ALLEGATION:

Youth A(14) alleged staff Mr. Belton stepped on his hand, while he was picking up a brush on 2/23/14; and Mr. Belton head locked him, it escalated into a fight that had to be broken up.

### INVESTIGATION:

Youth A reported he threw a hair brush at his door; and when he tried to pick it up, Mr. Belton stepped on his hand and pushed him on to the bed. He said he was restrained by Mr. Belton and Ms. Beaver; and he hit Mr. Belton with his loose hand. He said he was not sure where his hit landed, because "I was trying to get him off of me". He said they put a blanket up over his head because they said he was spitting; but he denied doing so. He said he couldn't breathe during that time; and he told the staff so; and Mr. Belton indicated he could breathe, that if he couldn't breathe he wouldn't be able to talk. He said then Ms. Beaver and "another lady" took him to the behavior management (BMR) room to calm down' and Mr. Belton walked away.

Youth A reported no marks or bruises from the incident, but said his throat hurt; that Mr. Belton had put his (Mr. Belton's) elbow on his (Youth A's) throat. Youth A said his roommate, Youth B was in the room during the incident.

Youth B(14) indicated Youth A was mad, threw a brush on the ground, Mr. Belton came into Youth A's room; and when Youth A tried to pick the brush up, Mr. Belton stepped on Youth A's hand, maybe by accident. He said Mr. Belton slammed Youth A onto the bed and was choking Youth A's throat. He said Youth A said he couldn't breathe; and Mr. Belton said if you can't breathe, you can't talk.

Youth B said Ms. Beaver, Mr. Belton, and someone else carried Youth A out of the room. He said someone had Youth A's collar, and Ms. Beaver and Mr. Belton had Youth A's legs. When asked if there came a time that someone put a blanket on Youth A, Youth B indicated Ms. Jones put a blanket on Youth A's face because they thought Youth A was going to spit on staff. When asked when did Youth A say he could not breathe; Youth A indicated Youth A said he couldn't breathe when, Mr. Belton had his elbow in Youth A's throat, not when the staff had the blanket on him.

Youth Specialist, Jazmon Belton reported Youth A had been escorted to the BMR room by himself and Mr. Childs earlier in the day; and that during that time Youth A cussed at them, threatened them, and told them they would pay. He said Youth A was in the BMR room five to eight minutes at that time. Later Youth A was in his room kicking on the door, he asked Youth A several times to calm down; and then Youth A threw a brush at the window. Mr. Belton went into the room to get the brush; and when he stepped on the brush, Youth A hit him on the arm. Then he took the arm Youth A hit him on and laid Youth A onto his bed. He said Ms. Jones had heard the commotion from the hallway; and she came and tried to help him get Youth A into the settle position. He said Youth A was resisting, Ms. Jones called Ms. Beaver; and once Ms. Beaver arrived he stepped away. Ms. Beaver and Ms. Jones got Youth A into the settle position.

Mr. Belton denied the allegations, and said he never put Youth A into a head lock, never stepped on Youth A's hand, or had his arm on Youth's neck or near the youth's neck. He said Youth A hit him twice, once in the leg when he reached to pick up the brush; and once in the back of the head, when they tried to get Youth A into the settle position. He indicated there was a time when Youth A hacked to spit and Mr. Jones said here is a blanket, and used it so Youth A wouldn't spit on them. He said Ms. Jones laid the blanket over Youth A's mouth, but not fully covering the youth's face. When asked if Youth A said he couldn't breathe, Mr. Belton responded yes, but that Youth A was already moving, and in the settle position when Youth A said that. Mr. Belton also acknowledged that he told Youth A if he couldn't breathe, he couldn't talk.

Youth Specialist, DelShanique Beaver, reported being unsure of why Mr. Belton went into Youth A's room. She said Ms. Jones called her to assist with bringing Youth A out of his room; that Mr. Belton Ms. Jones and Youth B were in Youth A's room when she arrived. When she walked into the room, Ms. Jones was standing; and Mr. Belton had Youth A spread out on the bed. Youth A was on his stomach, his arms were spread out; and Mr. Belton had his (Mr. Belton's) hand on Youth A's



back. She indicated Youth A was moving his arms, tried to tell her what was going on; and then Youth A tried to attack Mr. Belton; and she and Ms. Jones restrained Youth A. They then escorted him to the BMR room.

When asked if there was ever a time that they use a blanket to place over Youth A face or mouth, Mr. Beaver said Youth A didn't have a blanket on his bed, he had a sheet. After the incident Ms. Beaver did not observe any marks or bruises to Youth A; and he did not complain of any to her.

Supervisor, Patricia Jones acknowledged hearing a noise, which she assumed was the brush that was thrown. When she entered the room, she observed that Mr. Belton had Youth A stretched out on Youth A's bed; and Youth A was on his back. She said Mr. Belton was on one knee, lending forward holding Youth A's arms. She called Ms. Beaver, and upon Ms. Beaver's arrival; she and Ms. Beaver took over the restraint. They got Youth A into the settle position, and then escorted him to the BMR room. She acknowledged using a blanket during the incident. She said she took the blanket, a part of the gray covering on the youth's bed and laid it across the side of Youth A's mouth, not on his face. She indicated Youth A was trying to spit, and the blanket was to block any spit.

Ms. Jones denied seeing anything prior to observing, Mr. Belton having Youth A across the bed; and she denied hearing Youth A say he couldn't breathe at any time.

Reviewed:

- Incident report dated 2/24/14, 4:20 pm by Therapist S. Sibbett that indicated this allegation, and the next allegation of which reportedly occurred one hour before this incident. The incident report contained a nurse's follow up section by Nurse, Miller that indicated "right hand swollen from outer edge of edge side, the 4<sup>th</sup> finger from palm to knuckle". X-rays ordered.
- Written statement from Youth A that indicated he threw a brush out of boredom; and basically what he indicated when interviewed. He also report in this statement that Mr. Belton stepped on his messed up hand, and he stood up and Mr. Belton charged him, throwing him on the bed; and sticking his (Mr. Belton's) elbow in his neck, choking him; and said he couldn't breathe. That Ms. Beaver put a blanket on his head; and he said yes he hit Mr. Belton, because he felt like Mr. Belton was choking him, trying to kill him, so he used self-defense.
- Written statement from Youth B that basically indicated what Youth B reported when he was interviewed; and that Youth A hit Mr. Belton twice in the face, when Mr. Belton told Youth A if he couldn't breathe, he couldn't talk.
- Written statement from Ms. Jones that was basically a condensed accounting of what she reported when interviewed, minus information related to the blanket, its usage purpose, and whether the youth reported he couldn't breathe.

- Written statement from Ms. Beaver the indicated she was radioed, she and Mr. Jones placed the youth in the settled position, and then escorted him to the BMR room.
- Written statement from Mr. Belton that indicated, what he reported pertaining to what occurred prior to entering the youth's room and his purpose for entering the room. The statement also indicated he placed his foot on the brush, and slid it away with his foot; and Youth A assaulted him by striking his leg. He grabbed Youth A's arms, so he wouldn't be struck gain. Then Ms. Jones entered, assisted him, then Ms. Beaver as well; and then "We" placed him in the settle position, and escorted him to the BMR room.
- Email note from Nurse, Keith Miller dated 2/24/14 at 6:17pm to several facility administrative staff that indicated he assessed Youth A at 2:25pm; and Youth A complained "there is a hole in my hand". That Youth A's right hand was swollen starting from the right side of the hand to the 4<sup>th</sup> finger from palm to knuckles. That the youth insisted there was a hole in his hand and meat was missing. X-rays of bilateral hands would be ordered
- Email note from Nurse, Patricia Smoot dated 2/27/14 at 1:41pm to several facility administrative staff that indicated she assessed Youth A during the am shift on 2/25/14 in the presence of his mother for complaints of a whole in his hand. That the youth's skin was intact and no hole was in his hand, though Youth A insisted one was there. She spoke with the youth about the matter then and later with him and his Therapist Ms. Sibbett. That prior to this complaint Youth A had a x-ray of his hand on 2/5/14, due to him punching a wall on 2/2/14. That at the time of that x-ray, no factures were indicated; and as a result of the allegation that his hand was stepped on, an x-ray was ordered at the time of the incident.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of severe physical discipline inflicted in any manner.
<b>ANALYSIS:</b>	The two youths' and the interviewed staff's accounting of the incident varied; and it can't be determined whether Youth A's hand was stepped on purposefully, accidentally, or not at all. Yet Youth A's hand by his own account was not injured during the incident, as he reported receiving no marks or bruises from the incident. And the evidence does not support the other allegations as reported by youth, or severe physical discipline
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

On 2/23/14 staff Mr. Brandon Childs pushed Youth A causing Youth A to fall over the toilet and land on his roommate who was lying in bed.

**INVESTIGATION:**

Youth A said he was kicking his door; Mr. Childs came in and tried to calm him down. He tried to leave, Mr. Childs wouldn't let him leave; and Mr. Child grabbed him and pushed him toward a brick wall. He almost felt and Mr. Childs pushed him against the wall near the toilet, He grabbed Mr. Childs's shirt, and Mr. Childs was holding on to him; and Mr. Childs threw him to the wall and he landed on Youth B. Youth A reported no marks or bruises from the incident.

Youth A written statement indicated Mr. Child had not gotten him a sheet and so when Mr. Childs opened his door, he tried to get a sheet. Mr. Childs grabbed him pushed him toward he toilet, they grabbed each other, neither of them would let go and Mr. Child slung him toward Youth B; and he (Youth A) got restrained.

Youth B said Youth A was beating on his door, when Mr. Childs came in and Youth A tried to leave. Mr. Childs told Youth A he was not leaving and pushed him against the wall. That Mr. Child threw Youth A over the brick wall onto Youth B's side; then Mr. Child picked Youth A up and took him to the BMR room.

Youth B's written statement indicated Mr. Childs put Youth A against the wall, Youth A had Mr. Child's arm; and when Youth A would not let go, Mr. Child slammed Youth A over Youth B's wall, and then took Youth A out of the room.

Youth Specialist, Brandon Childs' written statement indicated the incident happened on 2/23/14 at 3:50pm. His statement indicated that while doing round he observed Youth A banging his head on the window. He opened the door, tried to de-escalated the youth; then Youth A tried to push pass him. That he attempted another verbal de-escalation method; and the youth continued to push pass him and became physically aggressive toward him; that he "had to blind side swope" Youth A and escort him to the BMR room.

Youth Specialist, Edgar Jones, report not observing any part of the incident. He said Youth A was being restrained when he came on shift. He escorted Youth A to the BMR room, but Youth A never told him that Mr. Childs did anything to him.

**Reviewed**

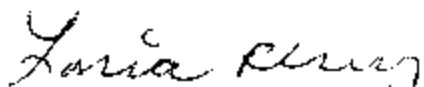
- A incident report dated 2/23/14, completed by Brandon Childs at 4pm; that indicated at 3:50pm, while doing rounds Youth A was observed self-harming by hitting his head against the door; and Youth A was physically managed and escorted to the BMR room. That while in the BMR room Youth A ripped padding off the wall, staff intervened and continued to de-escalate.

- Written statements from Youth A, Youth B and Mr. Childs as indicated in the body of this report.
- A incident report dated 2/24/14, 4:20 pm by Therapist S. Sibbett that indicated this allegation, and the prior allegation of which reportedly occurred one hour after this incident.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of severe physical discipline inflicted in any manner.
<b>ANALYSIS:</b>	The incident occurred in the youth's room and it can't be determined if Youth A's and Youth B's reporting of the incident is actual. There were no injuries reported by Youth A from the incident; and it's his' and Youth B' word against Mr. Child's. The evidence does not support severe physical discipline.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.



March 31, 2014

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



\_\_\_\_\_  
April 1, 2014\_

\_\_\_\_\_  
Linda Tansil  
Area Manager

\_\_\_\_\_  
Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

March 25, 2014

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2014C0420024  
Detroit Capstone

Dear Mr. Ziglor:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2014C0420024
<b>Complaint Receipt Date:</b>	02/27/2014
<b>Investigation Initiation Date:</b>	02/27/2014
<b>Report Due Date:</b>	04/28/2014
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Youth A(15) was trying to self-harm; and when staff Mr. Golden could not stop the youth, Mr. Golden pushed Youth A to the ground and kicked the youth in the head. Youth A had a scratch to his forehead, and appeared to have swelling to his right eye.

## III. METHODOLOGY

02/27/2014	Special Investigation Intake 2014C0420024
02/27/2014	Special Investigation Initiated - On Site Spoke with Director, Pernell Ziglor and Clinical Director, Karen Wickline
02/27/2014	Contact - Face to Face Interviewed Youth A, Staff, Dawn Baylis and John Golden
02/27/2014	Contact - Document Received Incident report, Nurse's Case Note
03/06/2014	Contact - Face to Face Interviewed Youth B and Youth C
03/6/2014	Special Investigation Completed- Full Compliance

### ALLEGATION:

Youth A(15) was trying to self-harm; and when staff Mr. Golden could not stop the youth, Mr. Golden pushed Youth A to the ground and kicked the youth in the head. Youth A had a scratch to his forehead, and appeared to have swelling to his right eye.

### INVESTIGATION:

All interviews were conducted by this Consultant with the DHS Worker, at the facility.

Director, Pernell Ziglor and Clinical Director, Karen Wickline indicated and there was no camera footage of the incident; as it occurred in Youth A's room.

Youth A reported he had been on one-to-one staffing, he was self-harming, and Mr. Golden tried to get him up and out of his room, but he was resisting. He said Mr. Golden threw him on to the floor, tried to punch him in his head; and swung and hit him up above his ear. He said Mr. Golden kicked him in his eye while he laid on the floor. It is noteworthy that Youth A had several red cut marks on his left arm, where he said he cut himself, and he had the remains of a sort of healing black right eye.

Youth A said Youth B, Youth C and another resident saw what was going on and came to his door; and Youth C tried to stop it. Youth A said he was too busy

defending himself to know how the other residents knew about the incident, but he speculated they heard something.

Youth A reported he was on the floor, when Ms. Baylis was trying to talk with Mr. Golden, telling Mr. Golden to stop, but Mr. Golden was not listening. Youth A said he was trying to kick Mr. Golden and he accidentally kicked Ms. Baylis.

Youth Specialist, Dawn Baylis, indicated she was on one-to-one staffing with Youth A when he pulled something out of his mouth and started cutting on his arm. She could not see the object; and he put it back in mouth. She called Mr. Golden for assistance; and Mr. Golden asked Youth A what he had in his mouth, to open his mouth, and instructed him to get up off the floor. She said Youth A had been up and down though out her time with him; and he was on the floor by his bed, when Mr. Golden tried to get him up to keep him from self-harming. She said Youth A went limp, when Mr. Golden tried to get him up, then Youth A started punching , kicking and scratching at them. They tried to get a grip on him to execute a proper restraint, but Youth A was kicking Mr. Golden. She called for assistance and Nurse Trotter and Nurse Bey came and grabbed Youth A. She said she pushed Mr. Golden out of the room, to keep him from further injury; and that at one point Youth A tried to run after Mr. Golden, and Youth A, while standing kicked her in her chest and she stumped.

Ms. Baylis said Youth A's was pretty wild during the incident; he was kicking, scratching; and never calmed down during her presence. The nurses took him to the behavior management room; and she alerted them of a possible object in his mouth. She reported never observing Mr. Golden hit or kick Youth A during the incident.

Mr. Golden denied the allegations. He said Ms. Baylis was on one-to-one staffing with Youth A called; and she called out for his assistance because she saw Youth A trying to self- harm, he put something in his mouth. He tried to persuade Youth A to follow Ms. Baylis's instruction. Youth A responded no and proclaimed to not care any longer; because his mother told him she was going to kill herself, therefore so was he. Mr. Golden continued trying to encourage Youth A, Youth A denied having anything in his mouth; and moved to the other side of his bed and sat down. Mr. Golden asked Youth A if he needed to go to the behavior management room to maybe punch the walls, to work out his anger; and Mr. Golden bent down and reached to put his arm around Youth A, and Youth A got half way off the floor, then dropped down to the floor. When Youth A dropped to the floor, Youth A started kicking him; and Youth A held on to Mr. Golden shirt. Ms. Baylis called for assistance; and the nurses came, tried to get Youth A's hand off of Mr. Golden's shirt; which Mr. Golden reported he pulled and ripped to get it free. He said after the nurses got there, he left, but Youth A got loose from one them, and Youth A hit Ms. Baylis in the chest.

Mr. Golden admitted Ms. Baylis was pushing him toward the door; but he was not going after Youth A. He said he trying to go one way, and they wanted him to go



another way. He said he never hit, kicked, or pushed Youth A; nor banged the youths' head.

Youth B said he was able to see what happen because he was in the group room across the hall. He said he heard a bumping noise, after he realized Mr. Golden had left the group. Youth B said Youth A was sitting in his room cutting his arm with a laminated piece of paper; and Mr. Golden asked Youth A several times to stop, but Youth A did not. He said Mr. Golden and another staff put on gloves and went in; and Mr. Golden pushed Youth A to the ground. He said Youth A had a piece of straw, Mr. Golden tried to get it; and Youth A would not open his mouth. He indicated Mr. Golden punched Youth A in the mouth; and he and Youth C tried to stop Mr. Golden.

When asked if he actually saw Mr. Golden push Youth A, Youth B admitted he had not. He indicated he saw Mr. Golden lean outward like he had pushed Youth A; and he saw Mr. Golden swing on Youth A two times. He said the first swing landed and hit Youth A; and the second swing was interrupted by Youth C, who grabbed Mr. Golden' s arm . He said he helped Youth C so Mr. Golden could not get to Youth A again; and Ms. Baylis held Youth A in his room so Youth A would not go after Mr. Golden. He indicated neither Youth A or Mr. Golden was saying anything at the time.

Youth C reported being unaware of an incident with Youth A; and when asked wasn't he in a room across the hall at the time, he acknowledged being there; but indicated he never saw anything.

Reviewed:

Incident report dated February 26, 2014, completed by therapist, S. Sibbett that indicated:

- Ms. Sibbett met with Youth A in the behavior management room after he was restrained. Youth A claimed Mr. Golden entered the room to help Youth A stop self-harming; and when Youth A would not stop; Mr. Golden pushed him to the floor and kicked him in the head. Youth A indicated Youth C entered the room and was holding him back, in an attempt to protect Youth A from Mr. Golden. Youth A acknowledged being taken to the behavior management room, yet he was not sure who brought him there; and Youth A indicated he wanted to "seek revenge" on Mr. Golden. Youth A indicated Mr. Golden's "outcome will be worse", Mr. Golden would be held accountable for his action; and he had a plan of action. Youth A would not share that plan with Ms. Sibbett; and indicated he was content "with going to prison".
- A Nurse follow-up section, completed by Nurse P. Smoot that indicated "Small scratch noted on the ® side of the forehead. No other new injuries noted. No complaints of pain. Remain on 1:1 @ all times.

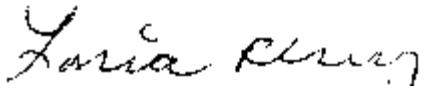
A Client Case note dated February 27, 2014 that indicated:

- During the am shift Nurse Smoot was called to assess Youth A, who was self-harming. The assessment note was as indicated in the above bullet point.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of severe physical discipline inflicted in any manner.
<b>ANALYSIS:</b>	The evidence does not support the allegations as reported by Youth A, nor severe physical discipline.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

The continued recommendation for a modification of the facility's license to a provisional license, in connection to special investigations 2014C0420003, 2014C04200010, and 2014C0420011 remains.

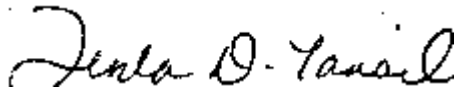


March 24, 2014

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



\_\_\_\_\_  
March 25, 2014

Linda Tansil  
Area Manager

\_\_\_\_\_  
Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

March 26, 2014

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2014C0420025  
Detroit Capstone

Dear Mr. Ziglor:

Attached is the Special Investigation Report for the above referenced facility. A violation was identified in the report, but based on actions already taken; and items and actions being addressed in the corrective action plan pertaining to special investigations, 2014C0420003, 2014C0420010, and 2014C0420011 no additional corrective action plan is required.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2014C0420025
<b>Complaint Receipt Date:</b>	02/27/2014
<b>Investigation Initiation Date:</b>	02/27/2014
<b>Report Due Date:</b>	04/28/2014
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/22/2013
<b>Expiration Date:</b>	03/21/2015
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

Youth A(15) was cutting himself and throwing objects; when staff Mr. Clay entered the youth's room, Youth A threw blood at Mr. Clay and Mr. Clay threw the youth against the wall.

## III. METHODOLOGY

02/27/2014	Special Investigation Intake 2014C0420025
02/27/2014	Special Investigation Initiated - On Site Spoke with Director Pernell Ziglor and Clinical Director, Karen Wickline
02/27/2014	Contact - Document Received Incident report, email note from Nurse Bey, medical, social & psychiatric data for Youth A
03/03/2014	Contact - Face to Face Spoke with Supervisor Alicia Yancey
03/03/2014	Contact- Telephone call made. Left message for Tony Clay
03/05/2014	Contact - Telephone call made Spoke with DHS Worker
03/06/2014	Contact - Document Received Email- DHS Worker's interview with Youth A
03/06/2014	Contact Face to Face- Spoke with Mr. Ziglor
03/06/2014	Contact- Telephone call made Left message for Tony Clay
03/06/2014	Contact Document received Email of DHS worker's interview of Youth A
03/12/2014	Contact- Telephone call made. Left message for Tony Clay
03/13/2014	Contact Document received Email with DHS interview of
03/14/2014	Contact Document sent Email of DHS Worker's interview with Nicole Richardson
03/25/ 2014	Contact- telephone call made Spoke with Mr. Ziglor -Exit

**ALLEGATION:**

Youth A(15) was cutting himself and throwing objects; when staff Mr. Clay entered the youth's room, Youth A threw blood at Mr. Clay and Mr. Clay threw the youth against the wall.

**INVESTIGATION:**

Director, Pernell Ziglor and Clinic Director, Karen Wickline were interviewed by this Consultant and the DHS Worker on February 27, 2014, this Consultant spoke with Shift Supervisor, Alicia Yancey on March 3, 2013; and Mr. Ziglor again on March 6, 2014. Youth A was forensically interviewed at Kingswood Hospital, by the DHS Worker on March 6, 2014; and Youth Specialist, Nicole Richardson was interviewed, by the DHS Worker by phone on March 13, 2014.

Mr. Ziglor indicated the incident occurred on February 26, 2014; and he arrived on the tail end of it. He indicated Youth A wanted a particular thermal shirt other than the one he had on; and the youth became agitated, and his behavior and upset grew more extreme. He said the youth found a sliver of glass, cut his hand, picked at the cut, and then began slinging his blood at staff. He said Ms. Richardson was first on the scene, Mr. Clay came to assist; and the youth reportedly slung blood on Mr. Clay, Mr. Clay pushed the youth against the wall; and Mr. Clay admitted it. Mr. Ziglor indicated he was not sure if Youth A slung blood on Ms. Richardson or if he spat on her, because Youth A had put the sliver of glass in his mouth. He said Nurse Welch reported seeing the sliver of glass on Youth A's tongue, when Youth A stuck his tongue out; when the youth was being assessed. Mr. Ziglor never saw the glass sliver, and said Youth A may have spit it out, because the hospital never found anything.

Mr. Ziglor reported it appeared that Youth A had a psychotic episode; the scene got bad and the police was called. He said Youth A was slinging blood, said he put the silver in his mouth and staff didn't know; and staff were trying to get to the youth, but Youth A was still slinging blood. He indicated Youth A even bit a plug out of staff, Mr. Purnell's arm. He indicated Youth A was not rational; and when Youth A was distracted, he and Program Coordinator, Mr. Williams were able to restrain Youth A. The police then cuffed Youth A and took him to Children's hospital. Mr. Ziglor indicated the youth's discharge plan was for him to be admitted to Kingswood.

Ms. Wickline called the police related to the incident, and reported that early on during the incident, Youth A was kicking and screaming and Mr. Purnell tried to restrain him using a blind-side swoop, but Youth A swung around and was kicking; so Mr. Williams said to stop. She said Youth A was shouting "they hurt me"; and "Mr. Clay said I did push him against the wall" She indicated Ms. Richardson and Mr. Clay both got upset and quit, they walked off the job. She indicated Youth A kept saying he had the sliver of glass in his mouth, but staff did not know, and and Youth A continued to threaten staff and police.

It is noteworthy that Mr. Clay had just a few hours earlier been involved in an incident with another youth and had been instructed by Ms. Wickline to not go back on the floor to work. Ms. Wickline and Mr. Ziglor were initially not sure how Mr. Clay became involved in this incident with Youth A. And Mr. Ziglor learned later that Mr. Clay was just walking pass when this incident was occurring; he was waiting to talk Mr. Williams. Mr. Ziglor indicated Mr. Clay was terminated, most specifically related to the prior incident of the day that Mr. Clay was involved (special investigation 2014C0420022).

Supervisor, Alicia Yancey, was asked how Mr. Clay became involved in the incident with Youth A, when he was supposed to be off the floor. She reported after she spoke with Mr. Clay about that incident (special investigation 2014C0420022); Mr. Clay said he was leaving. Though, she indicated she knew Mr. Clay was also waiting to speak with Mr. Williams.

Youth A was on the acute/violent floor. He knew the difference between the truth and a lie and agreed to tell the truth. He stated that he didn't remember the entire incident. He stated that he remembered that Mr. Clay assaulted him, choked him and punched him in the face several times. He stated that this was before he cut himself. He was standing in the hallway and Mr. Clay told him to go into his room and he refused. Mr. Clay then grabbed his arm and brought him into the room and then, once inside the room, started choking and punching him. He stated that no other residents observed. He stated that the only staff there at that time was Ms. Richardson. He stated she didn't do anything, she just laughed when Mr. Clay started punching him in the face. He stated that he then reached down and grabbed a piece of glass that was from a broken window and cut his hand and started throwing blood at Ms. Richardson because she laughed. He stated that no other staff members were there to witness any of this. He stated that he doesn't really remember what happened after he cut himself or who was there. He stated that he didn't have any marks or bruises after this except for the cuts he had done to himself.

He stated that the glass was from a window that had been broken for a few weeks and no one had fixed it. He stated it is a window in the hallway. He found the broken piece around the base of the window and took it to his room earlier in the day.

Ms. Richardson stated that she was willing to be interviewed over the phone for about 5 minutes but no longer. She stated that she is no longer working at Capstone and doesn't really want to get into anything that happened there. She stated that she doesn't have time to meet for a face to face interview. She stated that she was sitting in a one-on-one with Youth A and Youth A came out of the room and she asked him to go back in and he wouldn't, so Mr. Clay, who was standing nearby talking to her, told him to go into the room and continued to refuse. She stated that Mr. Clay then grabbed his arm and escorted him into the room. She stated that it was less than 20 seconds. She stated that he escorted him into the room and then came back out.

She stated that at no time did Mr. Clay hit or push or do anything other than walk him into the room.

It is noteworthy that Mr. Ziglor indicated Youth A was the type of kid who would lie on the floor or feel around on his fingertip for things; and that it may have been likely that if Youth A had seen something shining or glistening on the floor ,like a sliver of glass, he may have picked it up. He acknowledged that a door window, down the hall, from Youth A's room, was broken two days before the incident; and replaced earlier on February 26, 2014. He said the staff swept the area afterward; and video footage was seen for that day that showed the sweeping of debris in that area. Notably, that window repair appeared timely, and efforts to clean the area occurred.

It is also important to indicate that Mr. Clay was contacted in an effort to obtain his statement, related to the incident, but efforts were unsuccessful.

Reviewed:

Incident report by Ms. A. Yancey dated February 26, 2014 that indicated:

- Youth A began cutting his hand, staff intervened several times to prevent Youth A from harming himself, and Youth A began to throw blood from his wound.
- Several verbal de-escalation attempts by different staff was attempted, Youth A continued to throw blood; and he was restrained by Mr. Ziglor and Mr. Williams. Youth A refused treatment and was sent to Children Hospital.
- A Nurse Follow up section that indicated Youth A was alert and non-cooperative, very agitated, and continuous bleeding was observed from the youth's right hand. Agency psychiatrist notified, ordered to send youth to Children Hospital ER for further evaluation.

Nurse Note/email from Nurse Bey to Nurse Manager, Welch, Mr. Ziglor and other administrative staff that indicated:

- The information reported in the Nurse follow up section of the incident report. And that Youth A was aggressive, refused treatment; alleged he had a piece of glass in his mouth, and had initially refused to allow the nurse to examine his mouth. Youth A removed the small piece of glass from his mouth and showed it to Nurse, Smoot, Ms. Washington, Mr. Ziglor and Mr. Purnell. Nurse Manager, Welch who was also present, notified the agency psychiatrist; and youth transported to the hospital by four Detroit police officers; and DHS contacts made.

Video camera footage that showed:

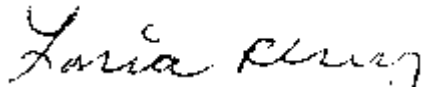


- Ms. Richardson sitting in a chair outside of the room; Youth A came out and stood on various sides of the chair, then behind it.
- Mr. Clay walking down hall, he stopped and appeared to talk to Youth A, who then appeared to push Mr. Clay. Hands went up and Mr. Clay appeared to grab Youth A, and took him into the room. Mr. Clay came out about three seconds later, then appeared to say something to Ms. Richardson, who jumped up entered the room and came right back out; and was seen walking down the hall. Mr. Clay stayed at the youth's door for a few seconds watching, but he did not reenter the room. Ms. Richardson returned, to the area, got something, and then sort of pulled Mr. Clay away. Ms. Wickline and Ms. Yancey then seen at the youth's door.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of severe physical discipline inflicted in any manner.
<b>ANALYSIS:</b>	<p>There was no actual video footage of the incident, and although Mr. Clay was seen entering and exiting the youth's room within seconds, the facility by way of their reporting to children services; and verbalization by Mr. Ziglor and Ms. Wickline, indicated Mr. Clay admitted he pushed the youth against the wall. It is also clear that the resident was able to find a sliver of glass that he was able to self-harm with which helped to lead to his hospitalization. The glass was apparently left over from a clean up after a window had been broken. The agency apparently cleaned up the area, but a small sliver of glass remained.</p> <p>Given the following, no further corrective action is required :</p> <ul style="list-style-type: none"> <li>• Mr. Clay was terminated the day of the incident.</li> <li>• The facility ceased the intake on placements for the residential unit this incident occurred, for a 30 day period.</li> <li>• The facility initiated an assessment and examination of its overall program; and hired a contractual professional to assist them with their assessment and enhancement of its programming and care of residents.</li> <li>• The corrective action plan issues being outlined for special investigation 2014C042003, 2014C0420010 and 2014C0420011).</li> </ul>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

The continued recommendation for a modification of the facility's license to a provisional license, in connection to special investigations 2014C0420003, 2014C04200010, and 2014C0420011 remains.



March 25, 2014

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Lonia Perry  
Licensing Consultant

Date

Approved By:



March 26, 2014

Linda D. Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

July 10, 2014

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2014C0420034  
Detroit Capstone

Dear Mr. Ziglor:

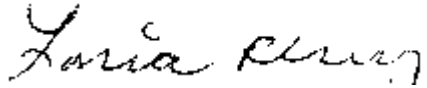
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

A handwritten signature in cursive script, appearing to read "Lonia Perry".

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2014C0420034
<b>Complaint Receipt Date:</b>	06/04/2014
<b>Investigation Initiation Date:</b>	06/04/2014
<b>Report Due Date:</b>	08/03/2014
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 4707 St. Antoine #506 Detroit, MI 48201
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	1ST PROVISIONAL
<b>Effective Date:</b>	03/31/2014
<b>Expiration Date:</b>	09/29/2014
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
On 6/3/14 Resident A was restrained then later alleged he was locked in his room, and jumped by two staff, while supervisor, Mr. Williams let it happen. Resident was sent to the hospital.	No
Additional Findings	Yes

Prior to the submission of this report to the agency, and close of the investigation, DHS initiated an investigation on this matter; after it had initially indicated it would not.

## III. METHODOLOGY

06/04/2014	Special Investigation Intake 2014C0420034
06/04/2014	Special Investigation Initiated - Telephone Spoke with Director, Pernell Ziglor
06/05/2014	Contact - Telephone call made Spoke with DHS worker
06/06/2014	Contact - Document Received Email from DHS Worker complaint not accepted
06/10/2014	Contact - Face to Face Interviewed Resident A, Supervisor, Marlon Williams, Youth Specialists, Jazmon Belton and Edgar Jones, spoke with Mr. Ziglor, viewed video footage
06/10/2014	Contact - Document Received Nurses note, hospital discharge
06/13/2014	Contact - Telephone call made Spoke with Youth Specialist, DelShanique Beavers
06/13/2014	Contact - Telephone call made Spoke with Nurse, Amaryllis Gilbert
06/18/2014	Contact- Telephone call made Spoke with Director, Pernell Ziglor RE: Seclusion logs – are still needed.
06/19/2014	Contact- document received Seclusion logs
06/19/2014	Contact Telephone call made Spoke with Quality Assurance Manager, Taneisha Henderson
06/20/2014	Contact- telephone call made Spoke with Mr. Ziglor, clarifications and Exit

06/20/2014	Special investigation completed- Sub Compliance
07/10/14	Contact Telephone call made Spoke with DHS Worker: Inquired as to completion of her investigation.

#### **ALLEGATION:**

On 6/3/14 Resident A was restrained then later alleged he was locked in his room, and jumped by two staff, while supervisor, Mr. Williams let it happen. Resident was sent to the hospital.

#### **INVESTIGATION:**

Director, Pernell Ziglor contacted this Consultant on June 4, 2014 and reported the facility had a resident to go to the hospital. He indicated Resident A was restrained in his room after he attempted to throw two cups of urine on staff who were attempting to clear Resident A's room of items to keep him from self-harming. He indicated he personally saw Resident A after the incident, and Resident A was fine, no issues or bruises were noted. Then approximately twenty minutes later he saw Resident A again and Resident A had a bruise on his arm; and Resident A began to make up stuff. Resident A reported he got closed in his room and beat up by staff; and that Mr. Williams let it happen.

Mr. Ziglor indicated the nurse had seen the resident for medication pass between 6:30 and 6:45pm, and the resident did not make a complaint, he checked on him again and the resident had urinated on the floor again, but he didn't voice a concern. When the nurse came back and conducted a formal assessment sometime after 7:00pm, Resident A made the allegations. 911 was called and Resident A was transported to Children's hospital for psychological assessment. Mr. Ziglor reported Resident A has a history of self-harming and acting out behaviors, inclusive of banging his head against walls, scratching his arms, being oppositional and refusing his medications. Further that Resident A had been urinated on staff from his room; and today when Resident A made the allegation against staff, he said he was beat up because staff had spit in his food and he knew it. Mr. Ziglor indicated Resident A's reporting of the allegations have varied. He indicated Resident A is diagnosed with intermittent explosive disorder and conduct disorder, but he suspects Resident A may also have a psychotic disorder and at times be delusional. Resident A is currently approved to receive medication via an injection if he refuses his meds; and stabilization is still pending. He indicated Resident A is resistant and unhappy about this matter.

When asked about Resident A being on locked seclusion and the reason for such, Mr. Ziglor reported Resident A was placed in his room on seclusion due to Resident A's attack on another resident earlier that day. He indicated the resident was not placed in the behavior management room because staff was not able to get him there. That when staff was attempting to process the resident out of his room that's when it was observed that Resident A had items in a cup that he was threatening to self-harm with. And that after Resident A's resistance to staff's intervention related to

the self-harming attempt, and him trying to throw urine on staff, his locked seclusion continued until he was able to be reintegrated with the group.

Resident A denied being restrained he indicated staff, Mr. Belton and Mr. Jones beat him up on June 3, 2014, at 9:00pm while he was in his room. He said Mr. Belton swung on him three to four times; hit him on the left side of his face and right eye. He said when he tried to block Mr. Belton's swings; Mr. Belton hit him on his right forearm. He said after Mr. Belton swung on him, Mr. Belton told Mr. Jones to swing on him; and Mr. Jones swung on him and Resident A almost fell to the floor. Resident A indicated he quickly stood up, but then Mr. Belton pushed him down hard to the bed; and when he put a grip lock on Mr. Belton, Mr. Belton picked him up from lying on his side and body slammed him down hard back and forth. He said while he laid on the bed, on his side, Mr. Jones pushed Mr. Jones' knee into his hand, then Mr. Belton hit his forearm and was hitting his face and neck. He said he went to the hospital and they gave him ice for his eye, which was swollen. He said his arm was also swollen, and he denied any marks or bruises to his neck, but said it hurts.

When asked why staff came to his room, Resident A indicated prior to staff coming to his room, Ms. Beaver noticed him pulling buttons of a jumper with his teeth and putting them in two cups with water. She asked for the items, but he refused; and she called Ms. Williams on the Walkie Talkie, and Mr. Belton and Mr. Jones came to his room. Mr. Belton came in first with a "cover" (blanket) and ran upon him, and covered his head causing the two cups he had to fall from his hand. He said at first he thought staff was going to give him an injection; though he admitted, when asked, that by 9:00pm it was past the time for medication dispensing. He said when he took the cover off his head that's when Mr. Belton swung on him. He said he spat and there was blood on the floor because the inside of his jaw was cut.

When asked if Mr. Williams was present when the incident he described occurred Resident A indicated Mr. Williams was not, that Mr. Williams was down the hall. He said Mr. Williams had been present that Mr. Williams grabbed the two cups, swept up the buttons then left. Resident A was not sure if Mr. Williams saw staff put the cover over his head; he said when Mr. Williams came back the incident was over. He indicated Ms. Beaver was also not present for the incident that she left after he refused to give her cup.

Resident A denied urine being in either of the cups, but said water was in one of them. When asked what happened with the cover/blanket, he said Mr. Williams grabbed it and his (Resident A's) folder containing his papers, and quickly removed everything from his room. Resident A said he was yelling and too focused on getting staff off of him to see who was around, but he does not think any other residents or staff observed the incident. Prior to the close of the interview Resident A asked if he had said Mr. Belton choked him, which he had not. He said when Mr. Belton held him on the bed Mr. Belton had his (Mr. Belton's) elbow pulled up under his neck (like a sleeper hold) and tried to put him to sleep. Resident A said he faked a seizure for Mr. Belton to stop.



Supervisor, Marlon Williams, Youth Specialists, Edgar Jones, Jazmon Belton and DelShanique Beavers all denied Resident A was beat up, nor observed him being hit or swung on by any staff involved. All indicated the resident was transported to the hospital by the police.

Mr. Williams reported being contacted by Ms. Beaver during the pm shift pertaining to Resident A. That Ms. Beaver indicated Resident A had taken buttons off of a jumper, and had two cups with items rambling in them, and Resident A said they were nails and he was going to assault staff should they enter his room. That Resident A had taken a nail out of a cup and was attempting to self-harm. Mr. Williams said Resident A was in his room due to this behavior, and that Resident A had already urination out his room door; and so when he contacted Mr. Belton and Mr. Jones about going to Resident A's room, he advised them the resident had two cups possibly filled with urine and to take precaution. He said the staff put on gloves, took a blanket.; Mr. Belton held the blank up and entered the room first , Mr. Jones and he entered next; and when Mr. Belton held up the blanket Resident A threw both cups of liquid, and they hit the blanket. He said Mr. Belton dropped the blanket and initiated the restraint assisted by Mr. Jones who grabbed the resident's arm. He said Resident A was standing near his bed and at first Resident A went with the restraint/ he was not resisting, and they ended up on the resident's bed. He said when he was almost done removing items from Resident A's room, (to prevent any continued self-harm), Resident A began to shake, went from his bed to the floor; and he told Mr. Belton and Mr. Jones to release the resident. Resident A then sat up and began cussing and verbally threatening staff; and Mr. Williams realized Resident A was faking a seizure. He said thereafter Resident A saw the nurse, but he was not sure how longer after. He indicated when they first entered the room Resident A must have thought he was getting an injection because Resident A said "I don't won't to get no shot".

Mr. Williams indicated Resident A never said staff swung on him; but the resident had alleged staff hit his face. Though Mr. Williams reported that at yet no time did Mr. Belton or Mr. Jones swing on Resident A; nor did either choke or put an elbow near the resident's neck, face, or put their knees to the resident's arms or hands. Nor was there blood on the floor after the incident; and no marks or bruises were observed to Resident A's body, pertaining to staff's intervention.

Mr. Jones and Mr. Belton acknowledged awareness of the incident, but denied the allegations reported by Resident A. Both reported being called to assist with Resident A who was self-harming; and that a blanket or some type of covering was used upon entering the resident's room because they suspected the resident had cups of urine, which he might assault staff with.

Mr. Jones indicated Resident A was self-harming and peeing out his door. He said Resident A was in his room on locked seclusion, but he was not sure for what. He indicated Ms. Beaver had observed the resident attempting to self-harm during

rounds; and Resident A had nails or screws in a cup. He said Resident A had wets sheets of paper from his journal covering the door window, they could not see inside the room, and knowing Resident A had pee in one of the cups, they used a "cover" as a shield to enter the room. He said this was the third incident whereby Resident A had used wet paper to conceal or use against staff; recently peeing on tissue, and making pee ball to throw at staff. He said when they entered the room Resident A threw one cup with screws and pee, and it hit the shield, those some got on Mr. Belton. He said there was another cup with just pee, but Resident A did not get a chance to throw it, because Mr. Belton was able to grab Resident A's left arm. He, in turn, took Resident A's right arm, and they held him in a loose escort like hold. They were not going to restraint him, but when Resident A saw Mr. Williams removing items from his room, Resident A "went crazy". Resident A began to struggle, told Mr. Williams he was going to hit him, tried to run after Mr. Williams, tried to spit, and they took Resident A to the bed. He said Resident A was on his stomach, but when Resident A tried to bite Mr. Belton, Mr. Jones turned Resident A's head to the side. He and Mr. Belton then sat Resident A up on his butt, and Resident A was calm.

Mr. Jones reported prior to Resident A departing for the hospital he overheard Resident A tell Mr. Williams, Mr. Belton hit him; and when Mr. Jones got to the hospital, Resident A told the police he (Mr. Jones) hit him. Mr. Jones said both were not true. He said neither he nor Mr. Belton hit the resident in the face or any part of his body, and no one choked him. When asked if any marks or bruises were observed to Resident A after the incident, Mr. Jones indicated Resident A had a scratch to the inside of one of his arms, which the resident had used the metal button to scratch it.

Mr. Belton reported he was told Ms. Beaver indicated Resident A had two cup containing screws, and a liquid, maybe urine. When asked for clarification about the nails Mr. Belton indicated they were buttons from the resident's jumper, and when buttons was questioned as being nails, Mr. Belton explained they were the metal portions of the snaps from the resident's jumper.

Mr. Belton reported when they entered the room, Resident A threw both cups and they hit the blanket. Mr. Jones grabbed Resident A, with a blind-side swoop and sat Resident A onto the bed, and he (Mr. Belton) held his hands on Resident A's knees. He said he never hit the resident in the eye, swung on , or choked Resident A, nor came anywhere near the residents' neck. He said Resident A just sat on the bed, and when Resident A saw Mr. Williams taking items from his room, Resident A began to cuss Mr. Williams, threatened to spit on them and began to struggle aggressively. When Resident A attempted to spit, Mr. Belton and Mr. Jones moved Resident A onto his side; and they held him until he calmed down. Mr. Belton said he held Resident A's legs together to keep him from kicking, and Mr. Jones had the upper part of the resident's body. Resident A said "ok I'm calm, I'll take my medication. When asked if they were in the room related to administering medication, Mr. Belton indicated they were not, that it was due to the resident self-harming. He said after they released Resident A he was verbally aggressive, but

nothing physical; and that at that time, Mr. Williams was not in the room. That Mr. Williams had swept items into the hallway, and had left midpoint into the physical management. He said no marks or bruises were noticed on Resident A after the incident; and Resident A did not report anything was wrong with him at that time.

Ms. Beaver reported observing Resident A attempting to self-harm while she was conducting rounds. She said Resident A told her he had removed little drill like nails or screws from the mirror in his room, and he had them in a Styrofoam cup. She said Resident A was shaking the cup, she could hear objects in it; and he refused to give her the cup. Resident A then said watch this, and he took one item out of the cup and began to scratch his inner arm. After she contacted Mr. Williams, he contacted Mr. Jones and Mr. Belton to come to the room. She and Mr. Jones had a good rapport with Resident A; and they tried to persuade him to give up the cup. She said when they entered the room, Resident A had placed the cup on the landing near the toilet; and she retrieved it. She could not recall whether the cup contained water, a liquid or urine; she said she did not look. She did not know if there was another cup with urine; she indicated she left after she got the one "cup and threw it in the trash, because that was the threat". She said when they were moving items from the room, Mr. Jones saw silver metal items on the floor; and it was realized these were not screws or nails but buttons from the resident's jumper. She said Mr. Jones examined the mirror in the room, and it was fine; and when she asked Resident A why he told her they were nails/screws, he laughed.

Ms. Beaver said she, Mr. Jones and Mr. Belton all entered the resident's room together; and she seemed surprised when a covering or blanket's use was asked about. She did not recall staff using any covering to enter the room. She indicated there was never a restraint of Resident A while she was in the room. She reported leaving the room after Mr. Williams came in, because her point was to get the cup. She said they were in the resident's room less than five minutes. That when she checked on Resident A a short while later that evening, he seemed fine; but he had paper and water all over his window; and told her no when she told him to clean it up. Aside from "the big long scratch" to Resident A's arm Ms. Beaver did not observe other marks or bruises to him; and she was not aware he had complained of any injuries or harm.

Nurse Amaryllis Gilbert, did not witness the incident, but indicated Resident A was restrained just before medication pass. She said he was dispensing medication and was unable to do his routine assessment right after the restraint, but she saw him. She said she dispensed his meds, which he took without problem; and he did not voice a complaint of any injuries at that time. She said when she return to assess Resident A twenty to thirty minutes later, he was talking fast and just kept saying his arm was hurting. He also asked her if she was going to send him to the hospital; and upon examination he had a "raised area" about the size of a golf ball on his right outer arm. She said the area was swollen, but not bleeding. She assessed he needed to be sent out for treatment and she notified the nurse manager; and the resident was sent to the ER by police transport.

**Reviewed:**

Video Footage which:

- Did not show the restraint, or an account of any happenings in the resident's room between the resident and staff.
- Showed Mr. Williams, Mr. Belton, Ms. Jones entering the room together at about 5:58pm and stuff being moving into the hallway from the room between 6:00pm- 6:07pm.
- Ms. Beavers in the hallway; then entering the room at approximately 6:00pm exiting a minute later, then returning and exiting again moment of each other.
- Ms. Williams exiting the room, kicking clothing items to the hallway at 6:05pm; and reentering the room seconds later; then exiting again at 6:07pm and returning second thereafter.
- Mr. Belton, Mr. Jones, and Mr. Williams all leaving the resident's room a 6:08pm.

Incident report dated 6/3/14 with a time of 6:15pm that indicated:

- Resident A attempted to self- harm with buttons from his jumper. Resident was very aggressive and spitting at staff when they intervened to remove any self-harming contrabands from the room. He was physically managed; and thereafter his seclusion continued.
- The Nurse's follow-up section indicated "Raised area on outer Rt forearm, sent to ER for evaluation". "Scratch observed on Lt forearm", no other redness or swelling observed. Resident complained of pain at a ten, area was treated, and he was placed on doctor's log.

Nurse's note dated 6/3/14 that indicated:

- Upon assessment scratches was observed on resident left foreman area cleanse and antibiotic ointment applied. A raised area approximately the size of a golf ball was observed on resident right outer forearm and resident complained of pain (10/10) pain meds given. Resident was sent out to the ER for further evaluation; and his father was notified.
- It was agreed by Mr. Ziglor and nurse manager resident to be transported safety to the ER by police.

Children Hospital Discharge instruction dated 6/4/14, 12:01 that indicated:

- Resident treated for a behavior outburst and contusions (bruises) to right arm.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of severe physical discipline inflicted in any

	manner.
<b>ANALYSIS:</b>	There were inconsistencies in staff's statements related to the incident, yet the evidence does not support the allegations as reported by the resident.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **ADDITIONAL FINDINGS:**

During the course of the investigation it was discovered the facility used the resident's room as a behavior management room. Additionally that thereon the facility did not conform to or did not document an administrative review, above the level a supervisor, once the resident was in the room beyond three hour

#### **INVESTIGATION**

Mr. Ziglor and Mr. Williams indicated Resident A was placed on locked seclusion due to his behavior. An incident report date June 3, 2014 for 12:30pm indicated Resident A punched another resident in the head area without warning, and Resident A was escorted from the area, and placed in locked seclusion, and one hour was listed for the length of time.

Mr. Ziglor reported the resident was escorted to his room after the resident attacked a peer; and he continued on seclusion because he was unable to be processed out due to his behavior. He indicated the resident was not placed on seclusion as punishment, but due to his assaultive and threatening behavior. Mr. Ziglor indicated the resident was not placed in the behavior management room, which he acknowledged was available for use, because he thought the facility could seclude the resident in this manner.

Facility seclusion logs indicated Resident A was placed on lock seclusion at 12:30pm, June 3, 2014; and showed fifteen minute monitoring, supervisory approvals documentations, and that seclusion continuing until 8:45pm that day. There were two separate seclusion logs for the time period 3:00- 3:15pm that showed contradictories. One documented the resident was sleeping, at both time intervals; and the other that he was standing quietly, and sitting quietly respectively. The seclusion logs did not show when the resident was released from seclusion, though the Quality Assurance Manager, Taneisha Henderson indicated, the seclusion ended at 9:00pm that day, when Resident A was transported to the hospital by the police. She said Resident A did not return to lock seclusion once he was released from the hospital the next day. The seclusion logs also did not show documentation of an extended use approval by way of an administrative review above the level of a supervisor within 48 hours after Resident A was locked in seclusion for more than three hours. Though, Mr. Ziglor indicated the administrative review occurred, notwithstanding the incomplete documentation. The seclusion logs also showed periods of times whereby Resident A's demeanor and emotional state at observational intervals were suggestive that the resident was calm, could have been released from his locked room, prior to his restraint on or about 6:15pm, and his ultimate departure to the hospital reportedly at 9:00pm. Though Mr. Ziglor reported efforts was made by the staff and therapist to process Resident A out of his room sometime between 3:00pm and 5:00pm, but the resident became upset

with the therapist, threatened to pee out his(Resident A) room, and did so. And then thereafter, the resident's behaviors escalated, cumulating to Resident A's restraint during the six o'clock pm hour; and his subsequent transport to the hospital that evening.

**Reviewed:**


- Incident report dated 6/3/14 for 12:30pm pertaining to Resident A's assault on another resident.
- Seclusion logs for Resident A dated 6/3/14.

<b>APPLICABLE RULE</b>	
<b>R 400.4545</b>	<b>Behavior management room.</b>
	(1) An behavior management room shall be approved in writing for use as such by the fire inspecting authority and the licensing authority.
<b>ANALYSIS:</b>	Resident A was locked in his room on seclusion for over eight hours, due to his behavior, and the resident's room is not an approved behavior management room.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4152</b>	<b>Behavior management room: policies and procedures.</b>
	(g) When the behavior management room is used for more than 3 hours, there shall be administrative review above the level of the supervisor who approved the extended use. This review shall be completed and documented within 48 hours.
<b>ANALYSIS:</b>	Resident A's room, which he was secluded in for over eight hours, was used as a behavior management room; and an administrative review above the supervisor and documentation of such within 48 hour was not documented.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan continuation of the facility's current licensing status is recommended.



June 20, 2014

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Lonia Perry  
Licensing Consultant

Date

Approved By:



Linda Tansil  
Area Manager

Date June 23, 2014



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

November 7, 2014

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2014C0420046  
Detroit Capstone

Dear Mr. Ziglor:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you need assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.



Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2014C0420046
<b>Complaint Receipt Date:</b>	09/08/2014
<b>Investigation Initiation Date:</b>	09/17/2014
<b>Report Due Date:</b>	11/07/2014
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2014
<b>Expiration Date:</b>	09/29/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
Resident M is locked down for about 3-4 hours at a time as a form of management for his negative behaviors. This type of punishment takes place daily.	No
Additional Findings	Yes

## III. METHODOLOGY

09/08/2014	Special Investigation Intake 2014C0420046
09/17/2014	Special Investigation Initiated - Face to Face Spoke with Director, Pernell Ziglor, reviewed resident case record, interviewed Resident M
09/19/2014	Contact- Document Received from Quality Assurance Rep Specific incident reports
09/29/2014	Contact- Document Received from Program Director Program Statement-Matrix program
11/6/2014	Inspection Completed-Sub Compliance

### ALLEGATION:

Resident M is locked down for about 3-4 hours at a time as a form of management for his negative behaviors. This type of punishment takes place daily.

### INVESTIGATION:

The complaint indicated Resident M is made to stay in his room during the day. That he is usually in his room locked down for three to four hours as a form of management for his negative behaviors. That this type of punishment takes place daily; and Detroit Capstone is not licensed to use total seclusion when dealing with residents.

Director, Pernell Ziglor indicated Resident M was in his room often due to his behavior, but mostly due to the resident's own wishes.

He indicated Resident M was admitted to the facility in July 2014; and Resident M had been hospitalized three times due to psychotic episodes. He indicated each time the resident stayed in short term hospitalization for about one week, and when he was stabilized, the hospital returned him to the facility. He indicated Resident M's medications, (especially, Haldol injections, if he must have that) makes Resident M sleepy; so staff had been advised to allow Resident M to stay in, or go to his room, if Resident M so chose.

Mr. Ziglor indicated on instances when Resident M had been placed in his room for attempts to harm others or himself, when staff tried to deescalate him out of the room Resident M would attack staff. He indicated Resident M has assaultive behaviors; and Resident M had attacked residents and staff, including the nursing staff during medication pass. He said Resident M's diagnoses include Bipolar with characteristics of Psychosis, and intermittent explosive disorder. He indicated Resident M is a placement from Hawaii; and the resident currently has one-to-one staffing, but often staff has had difficulty dealing with Resident M's psychosis. He said Resident M's next placement is a long term hospitalization facility. He indicated Resident M was scheduled for discharge from the facility, the day of this interview, but there was a problem with the sheriff transport. He indicated at this point, Resident M could discharge from the facility, any day, once appropriate transportation can be arranged.

Resident M reported that was a long time ago (three months or so) that he was confined to his room. He said he had sat in his room due to his medications, and things he was doing. He indicated once he was in there three days, that he tried to fight staff three days in a row; and every time staff tried to evaluate him to come out, he would fight them. He said he did stuff to get put in his room; he was aggressive, would pick up chairs and throw them; and he constantly tried to fight. He said he used to have a roommate, and when they would come in, he tried to fight them. He said he tried to run away once and they put him in his room.

Resident M said he was on lock seclusion once because he was plotting for three days on "how to kill someone, just because". During that time he could not recall how often staff came to check on him or whether they informed him of what he needed to do to come out. He said once he was in his room, there was no chance of him coming out, because once he was there, he was there all day. He said staff would come to let him out, but as soon as he got out, he would do something else. He said he did not remember half of the stuff staff told him he did, or that he did. He said his medications made him crazy. He said staff "gave me opportunity after opportunity to reflect, but I always messed up". He said he was "in a different zone then"; and stated that once he had seen his reflection in the mirror and he wanted to fight it; and he started banging his head on the wall. He said he was banging his head, it was bleeding it, and he was so bad, the police was called and he went to the hospital. He said he had banged his other times.

When asked what was different now that he is able to be calmer, be with around others, he indicated he took a trip to the hospital. That he came back three to four weeks ago. That once at the hospital he is a different person, he "did good"; and the hospital helps him. Resident M ended the interview with "It was my fault I was in my room, don't shut this place down. "

The following is also noteworthy:

- During the time of this complaint; this Consultant had completed a prior investigation of a complaint alleging kids were being placed in the BMR room

for no reason and locked in their rooms, refer to special investigation 2014C0420041; also see 2014C0420034.

- During the course of the investigation it was disclosed various seclusion logs were not available, the Director reported the Quality Assurance Representative had not been able to locate them, following their office move.

**Reviewed:**

Resident M's case record which showed:

- Resident M (DOB 7/10/96) is eighteen; and he was originally admitted to the facility 3/21/14.
- He was diagnosed with: Bipolar disorder, mixed type with psychotic features, Conduct disorder, ADHD, combine type (highly likely), Cannabis use disorder, Alcohol use disorder, Asthma, and Disruptive mood dysregulation disorder.
- His medications were indicated as Haldol 5xs a day, Depakote, 250mg in morning, Depakote ER 750mg at night; and Zoloft 50mg tablet am.
- Resident M was hospitalized in a mental health facility three different times following his original placement with the facility. He was sent to Children's Hospital from the facility on 4/29/14; and subsequently admitted to Hawthorne where he was discharged from on 5/9/14. He was sent to Children Hospital 6/10/14 for aggression, suicidal and homicidal threats and increased psychosis. He was admitted to Kingwood hospital 6/13/14, for suicidal ideation, depression, mood instability, and aggression; and discharged 6/16/14. He was sent to the hospital again on 8/21/14(Detroit Receiving), by the police after he became manic, which increased to psychosis and aggressive behavior and assault on staff; he was subsequently admitted to Hawthorne, then discharged.
- Incident reports dated 4/29/14, 6/10/14, and 8/21/14 pertaining to the respective event resulting in Resident M being sent to the hospital from the facility.
- Numerous nurse's notes/ assessments documenting Resident M's verbal and physical aggression, self-harming and psychotic behaviors and episodes; as well as various medication refusals.
- MARS.
- A Locked Seclusion log dated 8/20/14- that showed Resident M was placed on locked seclusion at 10:00AM, and released at 10:55 AM. Various fifteen minute checks and supervisory notification were indicated.
- A Locked Seclusion log dated 8/21/14 –that showed Resident M was placed on locked seclusion at 10:00AM, and released at 10:45PM. Various fifteen minute checks and supervisory notification were indicated.
- A 4/21/14to 7/2/14 Updated Residential Treatment Plan that indicated Resident M had consistently refused to participate in the therapeutic treatment program. That the most significant barrier to his treatment remained Resident M's mental health issues; and his emotional stability was a continued concern. The Updated Residential TreatmentPplan also indicated he had been hospitalized twice due to his mental health issues.

- A 8/15/14 thirty-day letter requesting Resident M's removal, due to his significant emotional, psychiatric mental health issues, and need for a long-term mental health and psychiatric treatment placement in an adult facility, preferably close to his family, so that they might engage in the treatment process.
- Matrix program statement which showed Resident's behaviors had initially fallen with the program's admission criteria.

<b>APPLICABLE RULE</b>	
<b>R 400.4545</b>	<b>Behavior management room.</b>
	(1) A behavior management room shall be approved in writing for use as such by the fire inspecting authority and the licensing authority.
<b>ANALYSIS:</b>	The evidence suggests Resident M was in his room for various periods of times due to his own wishes, side effects of his medication; and at times due to his severe mental and psychotic behaviors. In the latter the evidence suggests those instances were constant; and the agency tried to provide safety to both Resident M, and others, by allowing or ensuring he was in his room.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4152</b>	<b>Behavior management room; policies and procedures.</b>
	<p>An institution approved to use a behavior management shall establish and following policies and procedures specifying its use. The policy shall include, at a minimum , all of the following provisions :</p> <p>(d) Staff shall observe the resident at intervals of 15 minutes or less and shall record the observation in a behavior management log.</p> <p>(e) The log shall include all of the following information:</p> <p>(ii) Time of each placement.</p> <p>(iii) Name of staff person responsible for placement.</p> <p>(iv) Description of specific behavior requiring use of the room.</p> <p>(v) Time of each removal from the room.</p> <p>(f) For each instance in which a resident remains in the room for more than 2 hours, the log shall also contain hourly supervisory approval and the reasons for continued use.</p> <p>(g) When the behavior management room is used for more than 3 hours, there shall be administrative review above the level of the supervisor who approved the extended use. This review</p>

	shall be completed and documented within 48 hours.
<b>ANALYSIS:</b>	The evidence suggests Resident M was in his room for various periods of times due to his own wishes, side effects of his medication; and at times due to his severe mental and psychotic behaviors. In the latter the evidence suggests those instances were constant; and the agency tried to provide safety to both Resident M, and others, by allowing or ensuring he was in his room. Yet other than an 8/20/14 and 8/21/14 lock seclusion log, there were no other available seclusion logs that showed documentation of the requirements specified in (d) – (f) or that documentation of (g) was not required.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon of receipt of an acceptable corrective action plan, continuation of the facility's current license status is recommended.

**November 6, 2014**

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:

Linda Tansil  
Area Manager

Date November 7, 2014



RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



MAURA D. CORRIGAN  
DIRECTOR

December 2, 2014

Pernell Ziglor  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2015C0420001  
Detroit Capstone

Dear Mr. Ziglor:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.



Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Lonla Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2015C0420001
<b>Complaint Receipt Date:</b>	10/14/2014
<b>Investigation Initiation Date:</b>	10/16/2014
<b>Report Due Date:</b>	12/13/2014
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2014
<b>Expiration Date:</b>	09/29/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
Resident 2 choked Resident 1 and staff, Mr. Avery did not stop the incident from occurring.	Yes
Resident 3 alleged Resident 2 tried to “choke him up”, made him fall and staff did not intervene.	No
Additional Findings	Yes

## III. METHODOLOGY

10/14/2014	Special Investigation Intake 2015C0420001
10/16/2014	Special Investigation Initiated - Letter Email to the Director
10/20/2014	Contact - Telephone call received Spoke with Director, Pernell Ziglor
10/21/2014	Contact - Telephone call made Spoke with Complainant
10/21/2014	Contact - Document Received Incident Report and Addendum
10/29/2014	Contact - Face to Face Interviewed residents and staff, viewed video footage
10/31/2014	Contact - Telephone call made Spoke with Youth Specialist , Jeremiah Avery
10/31/2014	Contact - Telephone call made Spoke with Youth Specialist, Andre Bell
11/05/2014	Inspection Completed-Sub Compliance
11/05/2014	Comment- Exit

### ALLEGATION:

Resident 2 choked Resident 1 and staff, Mr. Avery did not stop the incident from occurring.

### INVESTIGATION:

A telephone conversation occurred with Director, Pernell Ziglor on October 20, 2014, and face-to face contact occurred on October 29, 2014. On the latter date, Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 7, and Youth Specialist,

Otis Johnson was interviewed. Youth Specialist, Jeremiah Avery was interviewed by telephone on October 31, 2014

Director, Pernell Ziglor indicated the therapist who wrote up the incident report did not include all the required information. That per review of what the therapist wrote it appeared that the staff involved allowed Resident 2 to just do something to Resident 1, but review of the camera footage did not show Resident 1 was choked. He said there was a point in the camera footage that the kids were off camera, but that Resident 2 was seen grabbing Resident 1's arm. Resident 1 showed no signs of distress. He indicated from the view of Resident 2's hands, and no adverse reaction from other peers sitting near Resident 1, the behaviors did not seem consistent with such an incident occurring. When asked if that was the case why they didn't do an amended incident report; Mr. Ziglor indicated they would do such and submit to the CCM staff.

Mr. Ziglor indicated Mr. Avery was supervising five to six residents and staff Mr. Johnson had stepped out of the room. He indicated Resident 1 is a youth with special needs who does not always tell the truth or does not tell the whole story. He indicated Resident 1 also seemed fixated on playing cards; he likes to play around; and these things sometimes gets him picked on, and taken advantage of by other residents.

Resident 1 when interviewed seemed confused about the allegation, and immediately began to describe another situation. When this Consultant informed him she was here to talk with him about an incident where he was supposedly choked, Resident 1 refused to talk about the incident. He said talking about it made him nervous, and he did not want to.

Resident 3 and Resident 4 reported being in the group room at the time of the incident and to seeing Resident 2 choke or attempt to choke Resident 1. Resident 6 and Resident 7 denied seeing or knowing what happened.

Resident 3 reported Resident 1 and Resident 2 were on different sides of the room. That Resident 2 was on the side in the corner by the TV; Resident 2 got up after Resident 1 said something. Resident 2 came up to Resident 1, told Resident 1 to shut up, to stop talking to him; then Resident 2 put his hands around Resident 1's neck. He said "this happens almost every day", when asked what happens almost every day, Resident 3 indicated Resident 2 tells Resident 1 to stop talking to him; and he (Resident 2) hits Resident 1 in the back or the head or something. (Resident 3 indicated Resident 2 had also choked him; this incident is investigated below).

Resident 3 indicated Mr. Johnson and another staff, whose name he could not recall were the two staff supervising the group. He could not recall how many residents were in the group. Resident 3 indicated he didn't know why the staff wouldn't have seen the incident.

Resident 4 reported Resident 2 “was choking” Resident 1 “that’s what I saw” and the staff “didn’t do nothing”. He said they were sitting playing cards; and Resident 1 “wasn’t doing anything to” Resident 2. When asked if Resident 1 said anything to Resident 2, Resident 4 indicated Resident 1 mumbled something that he was not sure of; and Resident 2 asked Resident 1 what he said, then came over and choked Resident 1, who made a choking noise.

Resident 4 could not recall the staff’s name who was on duty at the time of the incident; but indicated only one staff was in the room with seven kids. When asked if he thought the staff could see what was happening; Resident 4 indicated he didn’t know if the staff could or could not see what happened.

Resident 5 reported being in Group B and that Resident 1 was in Group C, but used to be in Group B. Resident 5 could not recall an incident whereby any resident was supposedly choked by another resident. He indicated he never saw Resident 2 hitting or touching Resident 1. He said Resident 1 “just bugs’ people all the time, asking people to play cards; he doesn’t accept no for an answer”.

Resident 7 denied seeing or knowing anything about the incident. He stated “I don’t know what’s going on here”.

Resident 2 denied hitting, choking or having an altercation with Resident 1; and he didn’t know why anyone would say he had.

Youth Specialist, Otis Johnson recalled the incident, but reported he was not present. He said he was on his break; and Resident 1 told him about it later. He said he and Mr. Avery were the only two staff working.

Youth Specialist, Jeremiah Avery acknowledged being the staff on duty at the time of the alleged incident. He indicated the incident happened out of his line of site. He said he had one of the toughest groups that day; and he had seven residents, and he was redirecting residents at the time. He indicated his goal is to aid and protect residents, and when he sees wrong doing, he acts on it, but in trying to direct seven kids, he missed this incident.

Mr. Avery reported he never redirected Resident 2 to stop, or to remove his hands from Resident 1, because he never saw the incident. He indicated there must have been a plot because one of the residents had his attention; the camera was back from the door; and the resident maneuvered in such a way that he wouldn’t be in the line of site. He said there was not enough staff. When asked what happened to this co-worker Mr. Johnson, Mr. Avery reported Mr. Johnson wasn’t present, but he was not sure why not. .

**Reviewed:**

Two separated incident reports related to the incident

- The first incident report dated October 10, 2014 related to an allegation on October 9, 2014 at 5:00pm. This report indicated Resident 1 reported to the therapist that he was choked by his peer Resident 2. That Resident 1 said staff Mr. Avery was present but did not stop the incident, Mr. Avery only instructed that resident to remove his hands from Resident 1, and to leave him alone. This report did not indicate a supervisory follow-up/response action taken comment.
- The second incident report dated October 20, 2014 by Mr. Ziglor related to the allegation on October 9, 2014 at 5:00pm. This report indicated on October 10, 2014 Resident 1 reported to the therapist that he was “choked” by his peer in the group room on October 9, 2014. That footage was reviewed regarding the incident; and Resident 2 was seen moving towards Resident 1 talking to him. Resident 2 did grab Resident 1 by the arm and moved him to another seat. It said the two residents could be seen talking and Resident 2 moved and then went back to talk with Resident 1. That Mr. Avery did look up and addresses Resident 2; Resident 2 returns back to his original seat; and Resident 1 remained seated. That Resident 1 displayed no signs of distress; and his peers seated next to him never responded or showed any signs of alarm. That Resident 1 was also seen sitting next to Resident 2 during a group discussion shortly after the situation.
- The Supervisor Follow-Up/Response Action Taken section of the second incident report indicated: Due to the original incident report being incomplete, this addendum was created. That due to Resident 1 sitting under the camera the resident could not be seen in full view; however Resident 2 was not seen making any aggressive movements other than grabbing Resident 1 by the arm. Resident 2 was provided with a consequence regarding his unauthorized physical contact with his peer.

Video camera footage that showed:

- One staff, identified as Mr. Avery in a room with seven residents.
- Resident 2 was seen sitting near Resident 7 who appeared to be talking Mr. Avery.
- Another resident was seen sitting on a desk or chair watching the TV; and his back is to several of the residents in the room
- Resident 1 appearing to play cards with Resident 5; and two other residents were sitting across or on the other side of them.
- One resident identified as Resident 3 was standing in the room with his hands up.
- Resident 2 got up, came across the room; he grabbed Resident 1’s arm; then moved Resident 1 over to another spot. Resident 1 and Resident 2 were seen partially on camera, but only Resident 2 upper body was seen. His hand appeared to move towards Resident 1 and Resident 1 appeared to move; and the other residents sitting by appeared to continue doing whatever they were doing.
- No actual choking on camera of Resident 1; nor did it appear Mr. Avery addressed what may have been transpiring between Resident 2 and Resident 1.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(2) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS:</b>	<p>The evidence showed:</p> <ul style="list-style-type: none"> <li>• Resident 2 physically bullied Resident 1 and put his hand around Resident 1's neck; and the incident was unbeknownst to the one staff on duty, Mr. Avery, because he was preoccupied with other residents.</li> <li>• The agency was out of staff-to-resident ratio; and Mr. Avery was trying to supervise seven residents on his own.</li> </ul> <p>The facility did not assure that continual protection, direct care, and supervision was provided to the residents, in this situation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### **ALLEGATION:**

Resident 3 alleged Resident 2 tried to “choke him up” made him fall; and staff did not intervene.

#### **INVESTIGATION:**

Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8 and Youth Specialist, Otis Johnson was interviewed on October 29, 2014. Youth Specialists, Andre Bell was interviewed by telephone on October 31, 2014

Resident 3 indicated that the day prior to the interview with this Consultant, Resident 2 tried to “choke him up” and made him fall while they were in the gym. He said Resident 2 had his hands on his (Resident 3's) neck and was squeezing it. He said he lost control of his body and almost blacked out. Resident 3 said staff Mr. Johnson and Mr. Bell saw the incident happen, told Resident 2 “don't do that no more”; and all they did was a FYI incident report. He said he had had a red mark on his neck; but no mark was seen by this Consultant the day of the interview. Resident 3 indicated Resident 5, Resident 6, and Resident 8 were present in the gym at the time of the incident.

Resident 4 did not have information related to this allegation; he reported not knowing if Resident 2 bullied or hit other residents.

Resident 5 said he is in Resident 3's group, and acknowledge being in the gym with them; but he never saw Resident 3 get choked by Resident 2 or any one.

Resident 6 acknowledged being in Group B along with Resident 2 and Resident 3; and being in the gym with them at the time of the alleged incident. However, he did not observe or recall any incident whereby Resident 2 choked Resident 3, or had any kind of altercation with him.

Resident 7 denied having any information related to the allegation. He stated “I don’t know what’s going on, I’m just here.”

Resident 8 also acknowledged being in Group B along with Resident 2 and Resident 3; and being in the gym with them at the time of the alleged incident. He indicated he heard something about something happening, but he didn’t see anything. He said he never saw Resident 2 choke or put his hands on Resident 3 nor saw Resident 3 do anything to Resident 2.

Resident 2 acknowledged being in the group with Resident 3, but denied being in the gym; and denied choking or trying to choke Resident 3. He didn’t know why anyone would say he had.

Youth Specialist, Otis Johnson indicated Resident 2 and Resident 3 were playing basketball. Resident 3 threw the basketball, it hit Resident 2 in the back and he and Resident began horse playing. Resident 2 was chasing Resident 3 and when Resident 2 caught up with Resident 3, Resident 2 sort of grabbed Resident 3’s arm, “as to motion chill out”. Mr. Johnson said he and Mr. Bell came up on the two residents and both residents said they were playing around. He said for Resident 3 to say Resident 2 choked him was not true. He said Resident 2 asked him later if he was in any trouble for the incident.

Youth Specialist, Andre Bell acknowledged supervising Resident 2, Resident 3 and other kids in the gym. He said Resident 2 and Resident 3 were horse playing, but he did not see it. He said Mr. Johnson said the boys were playing around, and Resident 2 acted as if he was choking Resident 3; but not for real. He said neither resident came to him about an issue; Resident 2 was not upset; and when he observed the two boys, Resident 3 was not showing indications of a problem. He said Mr. Johnson said he would write the horse playing incident up.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(2) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS:</b>	The two staff accounts of the incident differ, but the evidence does not suppose the allegations as reported by Resident 3.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>



### **ADDITIONALLY FINDINGS**

During the course of the investigation related to Resident 1 and Resident 2, it was discovered the facility was out of staff-to-resident ratio as required by its policy.

### **INVESTIGATION**

Mr. Avery, two of the residents interviewed; and video camera footage reviewed showed Mr. Avery was supervising seven residents by himself.

On October 29, 2014, Clinical Director, Dr. Boyce was asked to confirm the facility's staff-to-resident ratio and she indicated a 1:5 ratio is required for all groups. Facility staffing policy indicated a 1:5 staff-to-resident ratio is mandated.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff to resident ratio</b>
	Rule 127(1)The licensee shall develop and adhere to a written staff to resident ratio formula for direct care workers..
<b>ANALYSIS:</b>	The facility failed to follow its staffing ratio formula.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

### **IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan continuation of the facility's current licensing status is recommended

November 24, 2014

_____ Lonia Perry Licensing Consultant	_____ Date
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Approved By:

December 2, 2014

_____ Linda Tansil Area Manager	_____ Date
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RICK SNYDER  
GOVERNOR

State of Michigan  
DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING



NICK LYON  
INTERIM DIRECTOR

March 16, 2015

Kathleen Boyes  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2015C0420014  
Detroit Capstone

Dear Dr. Boyes:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HUMAN SERVICES  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT  
AMENDED**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2015C0420014
<b>Complaint Receipt Date:</b>	02/26/2015
<b>Investigation Initiation Date:</b>	02/27/2015
<b>Report Due Date:</b>	04/27/2015
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2014
<b>Expiration Date:</b>	09/29/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
On two occasions on 2/20/15, Resident A was assaulted by one of his peers. It is unclear where staff were located, and why the youth was not in the line of sight at all times.	Yes
Additional Findings	Yes

## III. METHODOLOGY

02/26/2015	Special Investigation Intake 2015C0420014
02/27/2015	Special Investigation Initiated - Telephone Spoke with Director, K. Boyes
02/27/2015	Contact - Document Received Incident reports
03/09/2015	Contact - Face to Face spoke with Dr. K Boyes, interviewed Youth A and other residents, viewed video footage
03/11/2015	Contact - Telephone call made Left message for Youth Specialist, Mr. Rhodes
03/11/2015	Contact - Telephone call made Spoke with Youth Specialist, KeShaun Powell
03/12/2015	Contact - Telephone call made Spoke with Youth Specialist Laquint Rhodes
03/12/2015	Inspection Completed-BCAL Sub Compliance

### ALLEGATION:

On two occasions on 2/20/15, Resident A was assaulted by one of his peers. It is unclear where staff were located and why the youth was not in the line of sight at all times.

### INVESTIGATION:

Program Director, Kathleen Boyes, provided the incident reports; and per this Consultant's review of them, the reports indicated both incidents occurred on February 20, 2015. The first incident was reported at 3:43 pm, and the second at 6:49 pm, involving two different peers. One incident report indicated, while exiting his room after reflection, Youth A was pulled into one of his peer's bedroom; and he was

in a physical altercation. The second incident report indicated, while in the group room, watching television, Youth A was assaulted by one of his peers. That incident report further stated, Youth A kicked his peer, in an attempt to defend himself; and staff intervened, physically managed Youth A, and escorted him to his room to process the incident.

Youth A (14) reported being at the facility for three months, and to being unfamiliar with any of the residents prior to his admission. He indicated he was in an altercation with two of his peers about a week ago. He indicated the first incident occurred with Youth F; and the second with Youth E. He said the first incident occurred after he and Youth F had been talking through the vents in their rooms. That Youth F was talking about his (Youth A's) baby sister, and threaten to kill her; and Youth F threaten him. So after reflection time, when staff let him out of his room, he walked slowly towards Youth F's room. He said he was going to confront Youth F, to let Youth F know he wasn't afraid of him, and that he couldn't treat him like crap. He said as he got to Youth F's door, Youth C pushed him; then Youth F pulled him into the room, and hit him in his face. He said Youth F threw the first punch; but he also swung on Youth F. He said the incident happened in a matter of seconds, and then Ms. Powell came into the room, separated them and placed him in a standing restraint. He was then taken to his room.

When asked how was he able to enter Youth F's room, wasn't the door closed/locked, Youth A reported Ms. Powell was walking and opening the doors to let the kids out, and her back was turned, as she went about opening different resident's doors. He indicated there were different kids in the hallway, as she went about letting the kid out, and she must not have been paying attention. He said he and Youth F did not exchange any words at the time; he did not scream, or say anything, and nor did Youth F. When asked how, then, did Ms. Powell know to come to the room; Youth A indicated she must have heard the commotion. He indicated there was not another staff person working with Ms. Powell, during the time of the incident, but Mr. Rhodes came later.

Youth A reported the second incident occurred, later in the day, in the group room. He said, he and Youth E had also been talking through their room vents; and Youth E also threaten his baby sister; and made a promise to beat him up. He said when they got to the dayroom; after Staff, Mr. Rhodes left the room, to talk with a kid, Youth E got up and hit him multiple times. He said he defended himself, and tried to kick Youth E; and Mr. Rhodes heard the commotion, ran in and restrained him instead of Youth E. When asked if he was restrained because he was the more aggressive one, when Mr. Rhodes approached him, Youth A said he was not sure, but indicated, he could have been.

Youth A reported there were seven or eight kids in the group room, at the time of the incident; and Mr. Rhodes was the only staff. He said Youth B was not in the room that Mr. Rhodes had taken him out.

Youth A denied receiving any marks, bruises, or injuries from either of the incidents, and indicated he saw the nurse after the first incident.

Youth B (14) reported being at the facility for three months; and acknowledged being in Group M. He indicated this group currently consists of seven residents, because one kid left today. He denied first hands knowledge of either incident involving Youth A. He said he was in his room. He said he heard later that Youth F pulled Youth A into his (Youth F's) room and attacked him.

Youth C (14) reported being at the facility for one year, acknowledged familiarity with both of the incidents; and reported being present at both. He said Youth A and Youth F had been "talking thrash" and threatening to beat one other up. He said when staff, Ms. Powell was "popping doors(opening them), to let kids out of their rooms, Youth A got pulled into Youth F's room by Youth F; and Youth A and Youth F fought. He said Youth A was screaming, the fight went on for about one minute, and Ms. Powell ran over and broke it up. Youth C indicated he was in front of kids as Ms. Powell popped the doors. He said there were about eight kids, but two were in their rooms. He said Ms. Powell was the only staff working at the time.

When asked if he pushed Youth A into the room, Youth C said, he pushed Youth A, but he was trying to push Youth A away from Youth F's door, because he knew they were going to fight. He said when he pushed Youth A, Youth F grabbed Youth A, and pulled him in.

In terms of the second incident, Youth C reported Youth A "was talking thrash" about Youth E, then Youth A, and Youth E started fighting. Youth C said he broke the fight up, by grabbing Youth E. When asked where the staff was, Youth C indicated Mr. Powell had left for another group; and Mr. Rhodes wasn't in the room at the time. He said, Mr. Rhodes came in while Youth E, and Youth A were fight; and Mr. Rhodes grabbed Youth A, and took him to the hall, then to his room. When asked what staff was in the room when Mr. Rhodes left, Youth C indicated no one, and then he said Mr. Rhodes called Ms. Beavers, who came about two minutes later, while Mr. Rhodes was still there. When asked how many residents were in the room at the time of the incident, Youth C said "a bunch". He named eight kids, including him-self.

Youth D (13) a resident at the facility for three months, reported knowledge of both incidents involving Youth A. He said, Youth A said, he was about to beat Youth F's "ass", and he walked into Youth F's room. Youth D said he told Youth A not to go, but Youth A did anyway; Youth F tried to push Youth A out; and Youth A hit Youth F in the face with a closed fist. He said Ms. Powell ran in, grabbed Youth F, and then Youth A swung on Youth F. Youth D said he was able to see all this, because he was behind Youth F's door. When asked how was Youth A able to get into Youth F's room, when the door would have been closed/locked. Youth D indicated Ms. Powell opened the door; and when Youth F was getting ready to come out, her back was to Youth F's door, and Ms. Powell could not see Youth A walk in. When asked

what other staff was working with Ms. Powell, Youth D indicated it was just Ms. Powell working, but Mr. Rhodes came afterward.

Youth D reported the second incident was between Youth A and Youth E. He said Youth A was talking about Youth E's uncle, who had just passed away, and Youth E said he was going to beat up Youth A, and "that's what he did." He said they( the same group of kids, from the earlier; Youth D named, seven residents, including himself) were all in the group room, and Youth E went up to Youth A while Youth A was sitting down. Youth A threw up his hands, "said I don't won't to fight no more", and Youth E beat him up. When asked how the fight got stopped, Youth D said he grabbed Youth E, put him against the wall, and told him it wasn't worth it. He said Mr. Rhodes, the staff on duty, was in the hallway with one of the other kids. That Mr. Rhodes heard the noise of chairs being pushed, and Youth A saying I won't to fight no more; and Mr. Rhodes came in and grabbed Youth A. He said Youth A was aggressive; and Mr. Rhodes called for assistance, and Ms. Beavers came.

Youth D did not observed any marks or bruised to either youth, after the incidents.

Youth E (14) and Youth F (16) both acknowledged being in Group M, and to being involved in an incident with Youth A.

Youth E indicated he was in his room sleeping, when the first incident occurred, with Youth A. He did not have any direct information about it, or what staff, or residents were there.

In regards to the second incident, Youth E said he fought with Youth A in the group room, after Youth A would not stop talking about his uncle (Youth E's). He said, he warned Youth A to stop playing around, but Youth A would not; that Youth A thought, he (Youth E) had said something about his sister, but he had not. He said Youth A kept it up, so he went over to Youth A, and told him, if he said something else "I'm hit you"; Youth E said something else, and "I hit him". He said Youth A fought back a little; and staff, Mr. Rhodes came in, and separated them. Mr. Rhodes pushed him to the side; and placed Youth A "in a proper restraint", and tried to walk Youth A out, but Youth A was still talking stuff about his uncle. When asked if he was grabbed by either of his peers, during the incident, he said yes a couple of them, and he affirmed that one of them pushed him against the wall, but he could not recall who those residents were. When asked what happened that staff did not see the incident, he indicated Mr. Rhodes was in the hall talking with a resident, so Mr. Rhodes may not have seen what occurred. He said there were five residents in the room at the time, because three other residents had asked to take a "self-call" (they asked to go to their rooms because they felt agitated).

Youth F reported he did not see what happened in the group room involving Youth A, because he was in the hall talking with Mr. Rhodes. He was not sure how many kids were in the room at the time, but reported there were eight kids in his group. He said, no staff was in the room, at the time of that incident.



Youth F indicated the incident he was involved in, with Youth A, happened earlier, that day. He said after staff, Ms. Powell opened this door for him to come out, after reflection, he went back to get his hair brush; and when he turned around to come back out, Youth A was coming into his room. He said he was facing Youth A, and he tried pushing Youth A back out; and he called for Ms. Powell. He denied any kid pushing Youth A into his room, but said he knew staff said someone did. He denied swinging on Youth A, or Youth A swinging on him at first; but said Youth A swung on him, after Ms. Powell grabbed him (Youth F). He said, Ms. Powell, the only staff presence at the time, was holding his arm, telling him "don't do it" (to not swing on Youth A), don't risk his home pass. Youth F recalls five kids being in the hall at the time of the incident. He said Mr. Rhodes came along after, about five minutes; that Mr. Rhodes had been on his way to get him for his visit.

Youth Specialist, KeShuan Powell reported not being on the floor during one of the incident related to Youth A; she was in the OCC (Operation Control Center). She indicated the incident she was present at, occurred as she was letting kids out of their rooms, following reflection time. She let two residents, out and went to the other side of the floor, to unlock doors; and various residents either did not come out, or were not scheduled to come out. She said Youth B was amongst those, who didn't want to exit, but Youth B changed his mind, sometime after she had unlocked Youth A's and Youth F's door. She said Youth A was standing outside his door; and Youth F's was on his way out, when Youth B began knocking on his door, to be released from his room. As she was checking on Youth B, she heard a commotion; and when she ran into Youth F's room, he and Youth A were going to go after each other. She pushed Youth A back; and she grabbed Youth F, tried to deescalate him/discourage from exiting the room, and going after Youth A. As she was trying to hold Youth F back Youth A smacked Youth F. She said Youth F said Youth A came into his room, and he was trying to get Youth A out. She said someone said Youth A was pushed into the room, and pulled in; but she did not see either. She said her back was turned away from Youth F's room, and after he opened it, she proceeded to another resident's door. She said, if she had known Youth A, and Youth F had had problems she would not have let them out, during the same time.

Ms. Powell indicated it was just her dealing with the residents at the time. That Mr. Rhodes was on his way, and that's why she did not let out all of the kids. He came at the end of the incident. Ms. Powell recalled three or four kids in the hallway at the time.

Youth Specialist, Laquint Rhodes, reported being employed at the facility for just over one month. He reported the first incident pertaining to Youth A involved Ms. Powell, as he had just come on duty; and had been on another floor dealing with a restraint. He said the incident was over by the time he got there; and he recalled there being five residents in the hall. Mr. Rhodes did not recall any other staff being on duty with the group. When asked if another staff was scheduled to work during that time, he indicated normally staff, Mr. Wiseman is scheduled; but he thought that

particular day was Mr. Wiseman's day off. He said, at times, the staff varied, so he was not sure who else was to be on duty. (It is noteworthy Ms. Powell had also alluded to Mr. Wiseman, mentioning that the kids would not behave that way with Mr. Wiseman).

With regards to the second incident, pertaining to Youth A, Mr. Rhodes acknowledged he was the only staff there at the time; and he was not in the room. He said, prior to the incident, the second staff, who had worked with him, had varied; at one time, it was Ms. Dunlop, at another time, Ms. Powell. He said after he got the kids into the group room, Youth F asked to talk with him, and they stepped into the hallway. He said, his back was turned, and that's when the incident happened between Youth A and Youth E. He said, by the time, he turned around, Youth E was over Youth A; they were going after each other, and he broke it up. He said there were seven other residents, in the room, and no other staff.

Mr. Rhodes said, there had been an incident earlier that shift; on another floor; and kids were being placed in their rooms, while the matter was dealt with. He said he did not have a "Walkie" talkie, but saw, and or heard that another staff was releasing their kids, so he thought it was ok, to release his group; he did so; and they went to the group room. He said he now realized it was wrong to do so, because they were then, placed out of staff-to-resident ratio.

**Reviewed:**

Incident reports

- Both were dated February 20, 2015.
- Each reported Youth A was assessed by the Nurse.

Video footage of incident one, which showed:

- Ms. Powell going up to various residents' doors, opening them, and proceeding to the next.
- Youth F was seen going back into his room.
- Youth A was seen at his door, then at one point in front of Youth C, at Youth F's door, Youth C's shoulder appeared to slightly nudge Youth A; and Youth A entered the room. Ms. Powell was seen running and going into the room a short time after.
- It could not be discerned from the video footage, if Youth A was pulled into the room; or what happened once he was inside. Video footage does not show inside the room.
- Four kids were seen in the hall during the incident, and Mr. Rhodes was seen coming on the floor, moving toward the room, at the end of the incident.
- From time to time two other staff were seen on the floor, and it wasn't clear if they were there in passing.

Video footage of incident two, which showed:

- Mr. Rhodes exited the group room into the hallway, with a youth, reported to be Youth F; and him appearing to talk with the youth.

- Youth A sitting; Youth E approached Youth A, appeared to say something, and motioned, as if he was going to hit Youth A.
- Youth A's arm/elbow up, as if blocking from Youth E; and Youth E swung on Youth A. Youth A got up, and he and Youth E are fighting. Youth A kicks Youth E.
- A couple of residents seemed to try to intervene between the Youth A and Youth E; and Mr. Rhodes grabbed Youth A.
- Seven residents are in the room.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(2) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS:</b>	<p>Youth A admitted he intended to go to Youth F's room to confront him; and when Ms. Powell was releasing residents from their rooms, Youth A, with an intentional or unintentionally nudge from Youth C, saw his opportunity, and he entered the peer's room without approval; and that lead to a physical altercation with Youth F. Staff quickly intervened to break it up.</p> <p>Ms. Powell appeared to be working singularly at the time of the incident, but she was not out of staff-to resident ratio, with the number of resident on the floor; other staff were nearby, and Mr. Rhodes came on the scene, soon thereafter.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(2) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.

<b>ANALYSIS:</b>	Mr. Rhodes was supervising seven residents in the group room by himself; he stepped outside the room to talk with one of them, he was distracted, his back was turned; and Youth E and Youth A engaged in an altercation. The lack of required staff to resident ratio likely contributed to Youth E being able to attack Youth A, and vice versa; and in this incident, there was a lack of direct care and supervision of the residents.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4109</b>	<b>Program statement</b>
	(1)An institution shall have a current written program statement which specifically addressed all of the following:  (c) Policies and procedures pertaining to admission, care and discharge of residents.
<b>ANALYSIS:</b>	At the time of the incident between Youth A and Youth E, one staff was supervising seven residents. The agency did not adhere to it policy, which mandates a one-to-five staffing ratio.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, continuation of the facility's current licensing status is recommended.

**March 13, 2015**

\_\_\_\_\_  
Lonia Perry Date  
Licensing Consultant

Approved By:

**March 16, 2015**

\_\_\_\_\_  
Linda Tansil Date  
Area Manager



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF HEALTH CARE SERVICES

MIKE ZIMMER  
DIRECTOR

May 18, 2015

Kathleen Boyes  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2015C0420016  
Detroit Capstone

Dear Dr. Boyes:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Lonia Perry'.

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317  
Enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2015C0420016
<b>Complaint Receipt Date:</b>	03/18/2015
<b>Investigation Initiation Date:</b>	03/19/2015
<b>Report Due Date:</b>	05/17/2015
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2014
<b>Expiration Date:</b>	09/29/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
On 3/15/15, Youth A was being physically aggressive toward another resident; and was physically managed and while being physically managed Youth A kicked off the wall. When assessed by the Nurse, Youth A complained of pain to the left wrist, but was not send out for further medical assessment until 3/17/17. He was seen at Children hospital on 3/17/15 at which time it was determined Youth A needed surgery to place a pin in his radius which has snapped during the restraint.	No
Additional Findings	No

## III. METHODOLOGY

03/18/2015	Special Investigation Intake 2015C0420016
03/19/2015	Special Investigation Initiated - Letter Email to agency Director
03/20/2015	Contact - Telephone call made Left message for complainant
03/20/2015	Contact - Telephone call made To DHS, as to if referral received
03/20/2015	Contact - Telephone call made Spoke with complainant- no referral to DHS, just BCAL
03/20/2015	Contact - Telephone call made Spoke with Director RE DHS referral. Consultant informed Youth A left facility today
03/20/2015	Contact - Document Received Incident report, other documents
03/20/2015	Contact - Document Received Text from Director, DHS took referral
03/20/2015	Contact - Document Received Emails from DHS
03/20/2015	Contact - Telephone call made Spoke with DHS Worker
03/20/2015	Contact - Telephone call made

	To Lincoln Center
03/23/2015	Contact - Face to Face Interviewed Youth A at Lincoln Center
03/23/2015	Contact - Face to Face Interviewed Youth B, Youth C, Youth D, and Youth Specialist, Bernard Tyler Jr. viewed video footage
03/23/2015	Contact- Document received Nurse note, Children hospital discharge instructions
03/24/2015	Contact - Telephone call made Left message for Nurse, Patricia Smoot
03/26/2015	Contact - Telephone call made Left message for Nurse, Smoot
03/26/2015	Contact - Telephone call made Left message for Dr. Bryant via his office
03/26/2015	Contact - Telephone call made Spoke with Dr. Bryant
03/29/2015	Contact - Document Sent Email to DHS Worker
03/31/2015	Contact - Face to Face Interviewed Youth Specialists, Antonio Dumas
03/31/2015	Contact - Face to Face Interviewed Youth Specialist, Jason Carter
05/08/2015	Special investigation –Full Compliance
05/18/2015	Comment- Email to and from the DHS Worker

#### **ALLEGATION:**

On 3/15/15, Youth A was being physically aggressive toward another resident; and was physically managed and while being physically managed Youth A kicked off the wall. When assessed by the Nurse, Youth A complained of pain to the left wrist, but was not sent out for further medical assessment until 3/17/17. He was seen at Children hospital on 3/17/15 at which time it was determined Youth A needed surgery to place a pin in his radius which has snapped during the restraint.

#### **INVESTIGATION:**

Youth A, Youth B, Youth C, Youth D, and Youth Specialists, Bernard Tyler Jr, Antonio Dumas, and Jason Carter were interviewed, by this Consultant, and the



DHS Worker. Each youth and staff acknowledged familiarity with Youth A, and of Youth A's restraint in the gym.

Youth A(14) was interviewed at his new location, Lincoln Center. Youth A reported his mother asked for his transfer from Detroit Capstone. He reported the incident related to his wrist occurred on the Sunday, March 15, 2015, between 1:30-2:00pm, following an altercation he had with Youth B, in the gym. He said Youth B swung on him, missed, and acted as if he (Youth B) was going to attack him, so Youth A, as Youth B was walking away, charged Youth B, and tried to get him in a head lock. Youth A said staff, Mr. Dumas, came; and put him in a restraint whereby his (Youth A's) hands were behind his back, "like a proper restraint." When ask if it was a proper restraint, Youth A said, "yes at first", but then he (Youth A) got aggressive, because he got defensive when he was touched, so he tried to head butt the staff. He said, Mr. Tyler had one of his arms behind his back, Mr. Dumas the other; and that assistance was called for; and Mr. Carter came and took over for Mr. Tyler. He said, as Mr. Dumas, and Mr. Carter were getting ready to take him out of the gym, Mr. Dumas bent his(Youth A's) wrist downward until he felt, and heard a cracking, and popping noise. He said it hurt, he started crying, and he was taken to the behavior management room (BMR).

When asked, whether at the time he heard the "cracking and popping", if he told one of the staff, Youth A indicated he told, Mr. Carter; and Mr. Carter didn't say anything. Youth A said, after the incident, Nurse Smoot, came and assessed him, and said his wrist was broken. When asked if the nurse said that, Youth A corrected his statement; and reported, he told Nurse, Smoot, it was broken and that he needed to go to the hospital, but she didn't listen to him. When asked what did the nurse do, Youth A indicated, she gave him Tylenol, and an ice pack. He said he was seen, by the nurse two or three times that day; and she still said it wasn't broke. When asked what did the nurse do each time, Youth A said, she gave him Tylenol and an ice pack. He said his wrist was swollen; and he could tell it was broken, because the bone didn't look right, and when he tried to bend it, or tried to pull it back and forth, or rotate it, he couldn't. He said it hurt.

When asked if he punched Youth B, Youth A said, he tried to put Youth B in a head lock, he never punched him. That when he tried to put Youth B in a head lock he used his left arm; and that was before his arm was broken, and he felt no discomfort at that time. When asked whether other residents were present in the gym, when he was restrained; in addition to Youth B, Youth A named, Youth C, Youth D, and two other resident who were present from his group(Group M) at the time of the incident. He said he was sitting on the sideline with Youth C, and the other residents were shooting hoops, with Mr. Dumas and Mr. Tyler. He said, Mr. Dumas, or Mr. Tyler should have been paying more attention to the residents. He said when he was restrained, his back was turned and he couldn't see the other residents, and they couldn't see him.

Youth A reported the next day his wrist was swollen; and when he saw Mr. Dumas, Mr. Dumas threatened him, Mr. Dumas said, "you snitched on me, we'll see, if you snitch on me again". When asked if anyone else heard Mr. Dumas, Youth A said his whole group was present, in the day room, at the time, but they weren't paying attention. Youth A said he went to the hospital thirty-six hours after the incident occurred. He said he told staff he was in excruciating pain; he was assessed by Nurse, Brown; and they sent him to the hospital. While at the hospital, the staff there, said possible fracture; and "then the x-ray showed a clean break going across".

When asked if he was in an altercation with another resident, later on, the day he was restrained, Youth A indicated he was in a fight with Youth C in their room. He and Youth C were having a "stinging contest", to see who could say the most insults. The game turned physical, after Youth C insulted his baby sister, using the "F" word. Youth C challenged him to fight, he said yes; he got up, and Youth C swung on him. He flipped and tripped Youth C using his arm and Youth C, fell and hit his (Youth C's) head on the corner of the bed. Youth C was bleeding, had to go to the hospital, and got two staples. Youth A said his room was moved.

When asked how the fight was stopped, Youth A said they stopped on their own after he flipped/tripped Youth C. He said he used his arm to grab and throw Youth C down, but he tripped him with his leg by wrapping them around them, then he took his arms and threw Youth C down; and Youth C hit the side of the bed. When asked what arm did he use to trip Youth C, Youth A said, he used his right arm, that he is right handed; and everyone thinks he used his left arm, but he did not (he said his left wrist was broken). He said he had a witness, Youth D, his roommate; and that Youth D tried to break up the fight because, Youth C and he (Youth A) were both bleeding. Youth A said, Youth C head was bleeding, and the back of his (Youth A's) leg was bleeding.

It is noteworthy that on more than one occasion during the interview, Youth A asked if his interview would be turned over to the court. And at the close of the interview he, asked what was going to happen to the staff who "possibly broke my wrist". Then he rephrased his statement to say, who "broke my wrist".

Youth C(14) acknowledged being in a fight with Youth A, later on in day that Youth A was restrained by Mr. Dumas and Mr. Tyler. He said, he and Youth A were fighting, because Youth A was trying to "roast" him (Youth C), and his deceased girlfriend. He indicated Youth A body slammed him on the side of the bed, and he went to hospital around 5:30pm, got back about 8:00pm; and he got 2 staples for head injury. When asked if Youth A was hurt from the fight, Youth C said the back of Youth A's leg was hurt a little. He said Youth A had broken or fractured his arm (he was not sure which); it was swollen from the wrist almost to the elbow. He said it was wrap at first; and it took a couple of days for them (staff) to take him to the hospital, because they didn't know it was broken or fractured. When asked if he knew what happened that Youth A's wrist got broken or fractured, Youth C said, no.

Youth C said the incident with he, and Youth A occurred in their room; and there was no other resident in the room. He said Youth D did not see the fight; Youth D came after the fight. He said Youth A attacked him first. That Youth A wrapped his (Youth A's) arms around him, he (Youth C) pulled Youth A off of him, and Youth started swinging on him. Youth C was not sure which arm Youth A used to swing on him; and he (Youth C) swung back, landing on Youth C's cheek a couple of times.

When asked, whether he saw an incident in the gym with Youth A and another resident earlier that day, Youth C, said Youth A ran up on Youth B. He said other than Youth A getting restrained, he didn't know what happened after that. He said Youth A was resisting the restraint, trying to head butt and elbow Mr. Tyler and Mr. Dumas. Youth C did not recall anything that Youth A, Mr. Dumas or Mr. Tyler said during the restraint, nor did he recall another staff being around. He indicated he didn't recall what Mr. Dumas and Mr. Tyler were doing before the restraint. He indicated typically when the staff are in the gym, "they sit, chill and watch the kids".

Youth D(13) acknowledged had been Youth A and Youth C's roommate. He said, he didn't see the fight start, but he tried to break it up. He had been asleep, when Youth A and Youth C started fighting; and he heard a big bump. He said, Youth A and Youth C were tussling on the floor; and they both hit him; "so I didn't try to break the fight up no more". He assumed Youth A slammed Youth C to the floor, but admitted he did not see that happened. He said he knocked on the door, and got a staff's attention; but he could not recall, what staff, maybe Ms. Dunlap. When staff got there Youth A and Youth C had stopped fighting. When asked if he saw blood on anyone, Youth D said the back of Youth C's head was busted open; but Youth admitted he did not see Youth C's head. He said Youth A had a cut on his leg, and there was blood on the floor.

Youth D reported, he was "hooping"; and all he witnessed related to Youth A and another resident, in the gym, was Youth A going out the door. He said two male, staff, had Youth A, their hand was on Youth A's shoulder; and Youth A swung on the staff. Youth D said three staff were in the gym; and two of them took Youth A to the BMR room. When asked if he noticed anything about, Youth A's arm, he said it was kind of swollen. He said a day later, staff took Youth A to the hospital; and Youth A came back with a cast on. He said Youth A had said his arm was hurting, and Youth A said he thought it was broken; and Youth D said, "but I don't know how his arm ended up like that though". When asked if he had ever seen Youth A try to hurt himself; Youth D said he had not; he said he heard Youth A trying to hurt himself. When asked what did he mean, he indicated he had heard another resident yell out from their room that Youth A was trying to hang himself with a jumper. Youth D said, when he saw Youth A after that, Youth A had a red mark on his neck.

Youth B (15) acknowledged some type of incident with Youth A in the gym; and indicated prior to going to the gym, Youth A was saying stuff about him. He reported Youth A, was on restriction, so Youth A was sitting on the sideline in gym.

Youth B said, as he went to get water, “I jumped at him”, and went on. After he “jumped at” Youth A, Youth was coming behind him, and Youth B turned around, and staff told him (Youth B) not to do anything. Youth B said staff, Mr. Dumas and Mr. Tyler grabbed Youth A; and they told him to calm down. Youth B said the last thing he saw was Youth A “trying to get away from staff to try to come toward me”. Youth B said staff had Youth A’s arms, which were in front of him; and that there was never a time Youth A’s arms were pulled behind him. Youth B did not recall another staff, other than Mr. Dumas, and Mr. Tyler, in the gym, or coming to the gym. He said Mr. Dumas took Youth A out of the gym; once someone brought keys, but he could not recall who brought the keys; he said “they were gone when they(the residents) were done playing basketball), He said after the incident Youth A never came back to any of their classes.

Youth B said before Youth A left Capstone, Youth A had on a cast; that Youth A had been in a fight with Youth C. Youth B admitted he did not see Youth A and Youth B fight; he said Youth C was telling him this information through the vents of their room; and Youth C said his (Youth C’s) head was bleeding. Youth B said, Youth C told him Youth A “was trying to fight him, and he was punching him, then slamming him on the floor”. That Youth C said Youth A “was trying to bend his (Youth A’s) arm on purpose, so he could go back to the hospital”. When Youth B was asked if he had ever witnessed Youth A trying to hurt himself, Youth B indicated he had not.

Mr. Tyler reported he and Mr. Dumas were playing two-ball with a couple of the residents, when he heard a “dump”. He recalled looking over, and seeing Youth A on Youth B’s back; and Mr. Dumas grabbing Youth A, via a blind-side swoop physical management intervention. Mr. Tyler said he watched for a couple of seconds, as he thought Mr. Dumas had Youth A, but Youth A tried to head-butt Dumas, so Mr. Tyler intervened by turning Youth A head, so Youth A could not head-butt. He did not have Youth A’s arm. He said Mr. Dumas placed Youth A on the wall,( whereby Youth A was facing the wall and Mr. Dumas was in back of Youth A) and was giving Youth A directions to calm down. Youth A wouldn’t follow directions, was kicking and trying to get free from the restraint. He called for assistance, Mr. Carter came in; and Mr. Carter, moved Youth A over; and Mr. Carter and Mr. Dumas took Youth A out of the gym.

Mr. Tyler did not recall what Youth A was saying during the restraint; he indicated Youth A never said his arm or wrist was hurting, nor said anything about hearing a pop or crack. When asked if he saw Youth A’s hand/arm/wrist while in the restraint, Mr. Tyler indicated he did not, that afterwards he stayed with the group.

Dr. Bryant was interviewed, by this Consultant by telephone; and he recalled two phones call from the nursing staff related to a kid (Youth A), the week of March 15, 2015. He could not recall the exact day, or what reportedly happened initially, but recalled being told about a restraint. He also recalled that the kid had pushed someone, and that’s when the swelling occurred, but x-rays had already been ordered. He said the nurse said the child’s hand was swollen, and he advised to

keep close eye on it. He said, they always call a x-ray service, and was trying to monitor it until the x-ray service came, but the kid got sent out before the service came to the facility. He said the nursing staff shift changed, and the nurse said it was getting worse; and that when Youth A went to the ER. He said the “kid had hit somebody and he had pain in the wrist, and he went to the ER”. That the parent came to visit and the kid went to the ER; and that when they noticed the fracture.

Dr. Bryant said the nurse had ordered an x-ray, and the x-ray service that the facility uses for x-rays was coming the next day, but the kid hit someone; and that from what he was informed that’s when the swelling occurred, and that could have caused the fracture. He said from what he understood the kid went to the hospital with the parent after his visit.

Mr. Dumas, indicated he was participating in a basketball game with residents in the gym, “when I heard”; which he indicated, he realized, Youth B and Youth A sort of grabbed one another, and he approached them. He said Youth B said “I’m good; and he had already blind-sided swooped Youth A. He tried to talk with both residents, at the same time; and Youth A tried to head-butt him, missed; and he let Youth A go. He said Youth A took a swing at him, and he tried to physically managed Youth A again with a blind-side swoop. He said he got assistance with the physical management from Mr. Tyler and Mr. Carter. He had Youth A against the wall when Mr. Tyler and Carter came; and he and Mr. Carter escorted Youth A to the BMR room.

Mr. Dumas indicated Youth A was making verbal threats, cussing, and using words like “F U” doing the whole time of the physical management; and Youth A tried to head-but him, but Youth A never said his hand or wrist hurt. Mr. Dumas denied hurting Youth A; and when asked if he bent Youth A’s wrist backward, Mr. Dumas said, “No”. When asked if he told Youth A, the next day, not to snitch on him, he said, “No”; and that he did say that because, “I wouldn’t tell him that.

Mr. Carter indicated he is a floater staff, and he was called to the gym for assistance. He said, when he got there, Mr. Tyler, and Mr. Dumas had Youth A in a restraint. He said Youth A tried to head-butt Mr. Tyler, so he (Mr. Carter) switched out with Mr. Tyler. He said Youth A never complained of pain during the restraint, and did not have tears in his eyes, “he was just really aggressive”, He said, Youth A had been in a fight with another resident; so Youth A was still being aggressive, because he was being restrained.

Mr. Carter said after the restraint he, and supervisor, Ms. Yancey had Youth A in the BMR room; and Youth A was complaining about his arm, not his wrist. He said Nurse, Smoot had Youth A to move his arm and Youth A was able to move both his wrist and arm. Mr. Carter did not noticed if Youth A’s wrist was swollen at that time, time, and he never heard the nurse say anything about Youth A’s wrist being swollen.

When asked whether he saw Youth A later that day or the next day; and whether Youth A complained about his wrist, Mr. Tyler indicated when he did see Youth A, the youth complained about his wrist, in general, that Youth A said he had gotten into a fight with Youth C. But, that Youth A never said he hurt his wrist in the fight with Youth C. Mr. Carter said the day of the restraint Youth A's wrist looked fine, but the next time he paid attention to Youth A's wrist, Youth A had a cast on, and that was a couple of days later. He said then, when he was on 1:1 with the youth, and the two of them were walking, Youth A said his wrist was broken.

When asked if he had ever observed Youth A to self-harm. Mr. Carter recalled the youth purposefully trying to bang his head, on the floor, during another restraint, one week prior. Mr. Carter said he used his own hand to safeguard the youth's head, at that time.

It is noted that the Director, Kathleen Boyes was asked if staff were to be participating in a basketball game with the resident, when they were to be supervising them; she indicated staff are to be watching, and interacting with the kids within protocol. She indicated Youth A had also self-harmed in the past, to get attention, to gain access out of the facility; and that he had purposefully hurt his knee, a week or so ago in his room.

**Reviewed:**

- Incident report dated, March 15, 2014, at 12:40PM that indicated, during gym activity, Youth A became upset with Youth B for running towards him. Youth A began grabbing and punching Youth B. Staff attempted to separate the two residents. Youth A began to physically assault staff by hitting and attempting to head butt them. Staff physically managed Youth A; and while being physically managed Youth A kicked off the walls. He was escorted to the BMR room, and the supervisor and nurse were notified.
- Video footage, March 15, 2015, 12:43-12:46 pm that showed: residents engaged in basketball; Youth A sitting on the side bench; Youth B going towards Youth A, and making a jerking/ lunged motion at Youth A, then Youth A getting up going after Youth B. Youth A was on Youth B's backside; and Mr. Dumas grabbed Youth A. Mr. Dumas struggled with Youth A, got him to walk, still struggling; Mr. Tyler intervened, grabbed Youth A's arm. Mr. Tyler also had Youth A, but was struggling to get him in control. At one point Youth A kicked off a wall. Then Mr. Tyler and Mr. Dumas had Youth A on the wall, Youth A tried to head-butt Mr. Tyler; Mr. Carter entered, Mr. Tyler released Youth A; and Mr. Carter and Mr. Dumas took Youth A out of the gym. Mr. Tyler remained in the gym with other residents.
- Email Nurse's note dated Sunday, March 15, 2015, 4:55PM from Diane Gaston, LPN, to nursing staff, and various administrative staff, inclusive of Dr. Boyes and Youth A's Therapist, Alesha Barnes. The nurse's note indicated, "On 3/15/15 approximately at 3:45pm writer assessed resident (Youth A), after he had been involved in a physical altercation with his roommate in their room. Assessment revealed a linear scratch approximately 2 inches long on

- left heel with minor bleeding noted. First aid provided, bleeding stopped, area covered with a band aid. Resident denied any pain or discomfort. Nursing portion of Acadia form completed, and given to shift supervisor, Ms. Beavers. Resident is already on the NO SPORTS LIST.”
- Email Nurse’s note dated Monday, March 16, 2015 11:15PM from Tyree Brown, LPN, to nursing staff, and various administrative staff, inclusive of Dr. Boyes, and Youth A’s Therapist, Alesha Barnes . The nursing note indicated “On 3/16/15 approximately 6:15pm writer was summons to assess resident (Youth A) due to swelling in the left hand. Writer observed severe swelling to the left hand extending to the middle arm. Resident complained of pain rating the level 10/10. Writer treated resident with Tylenol 500mg x2 equal 1000mg and a ice pack. Resident was not able to complete ROM due to swelling and pain of the extremity. Writer verbalized the findings with Dr. Bryant and was instructed to send resident out to be examined if deemed necessary. Writer then received a report from staff that this resident was manipulating the extremity to swell by constantly dangling the arm lower than the heart which increases the swelling. Writer then advised Dr. Bryant of the report and also notified the therapist and the family that the decision to send resident out was put on hold. Writer was again summons towards the end of the shift approximately 10:15pm for the complaint of pain and increased swelling. Writer observed the extremity again with a fellow nurse RN Butler and treated with ice and given Motrin 600mg PO. Resident still could not complete ROM and the decision was made collectively to send resident out for further evaluation, Writer informed PM staff supervisor the decision to send this resident to Children’s Hospital via Capstone transportation vehicle. Writer informed parent”... “and direct supervisor Nurse, Evans of the decision. The nursing portion of the I.R. and Arcadia was completed and given to staff supervisor, Ms. Beavers.”
  - Email Nurse’s note dated Wednesday, March 18 2015 11:15PM from Patricia Smooth, LPN to nursing staff and various administrative staff. Nursing note email from Patricia Smooth. The nursing note indicated Youth A “attempted to assault staff during am shift on 3-15-15. Upon assessment this writer noted swelling of the left wrist.” Youth A “was able to move wrist and fingers.” Youth A “did complain of pain for which prn medication was given for the complaint and a ice pack was provided for the swelling. This writer informed Dr. Bryant of this incident informing him of the x-ray and medical treatment. Dr. Bryant was fine with this assessment requesting we let him know of the x-ray results. Follow-up with Dr. Bryant on 3-16-15 who requested that we wait for the x-ray results before proceeding any further, continue with prn and ice pack. Technician will be out on Tues 3-17-15. This writer provided (Youth A) with pain medication for comfort of pain and an ice pack for swelling.”
  - It is noted, the Director, Dr. Boyes indicated Nurse, Smoot’s assessed Youth A on the day, and shift of the incident, and Nurse Smoot documented that assessment later. Nurse Smoot was contacted, by this Consultant, for interview, but she did not call this Consultant back.

- Incident report dated March 15, 2015 at 3:25PM that indicated during reflection time Youth A alleged to staff he and Youth C were involved in an altercation. This incident report indicated, supervisor, and nurse on shift notified; and resident's peer moved to prevent any further incidents
- Email Nurse's note dated March 6, 2015, 11:18pm, to nursing staff, and various administrative staff, inclusive of Dr. Boyes and Youth A's Therapist, Alesha Barnes, from Diane Gaston, LPN, that indicated she was requested to assess Youth A on 3/6/15 at approximately 4:30pm for an injury sustained in his room. Resident said he tripped and bumped his knee against the cement partition in his room. The assessment revealed swelling on the left lateral side of the knee; and that resident indicated his pain level as 10/10 on the pain scale. Resident was given Motrin 400mg by mouth, and an ice pack; sent to Children's hospital for further evaluation; and the child's mother, and CMO worker notified.
- DBI Medical Offsite Encounter form that indicated "L lateral muscle injury. And Children's Hospital, Emergency discharge instructions, that indicated "soft tissue injury".
- FYI Email note, dated March 8, 2015, 11:12pm, from supervisor, DelShanique Beavers, to other DBI supervisors, and various, administrative staff, inclusive of Dr. Boyes and Youth A's Therapist, Alesha Barnes that indicated on 3/8/15 at approximately 8:50pm Ms. Beaver observed Youth A in his room and he appeared upset, and when she entered and spoke with him Youth A stated "I am tired of being here, my peers keep bothering me say that I lied about my knee." That when she asked what happened to his knee, Youth A said he hit it on the partition in his room Friday. The Youth A stated "F it I lied about hitting my knee, I just wanted some attention, and I have been trying to get attention; This is the only way I knew how: I always get attention at home; I missed my mom and wanted to see her". That Youth A was informed lying is not a way to gain attention, staff and supervision are available to speak with him.
- Client case notes from Youth A's Therapist, Alesha Barnes dating back to a family session of February 25, 2015, whereby Youth A "acknowledged that he used his violence and suicidal ideation/gestures in order to manipulate and "get what he wants."" And a March 10, 2015 individual session on "Behavior-inappropriate acting out in order to gain attention: purposefully harming himself in order to go to the emergency room on 3/6/2015."; and discussion with Youth A about that. And a March 13, 2015 phone contact with Youth A mother apprising her of Youth A's "suicidal behavior last night", and "of the manner and the bruises; as well informing her the youth was placed on close observation, and Youth A "was able to contract for safety".
- A March 16, 2015 Family session note, that noted Youth A's parents were informed that Youth A displayed aggression on Sunday, including assaulting a peer, who was sent to the hospital; as well as, assaulted staff. This family session note indicated the parents indicated not knowing what would work with the youth, that he seems "to do whatever it takes to get what he wants" in home and in placement or hospital." This family session note also



indicated, Nurse Brown came to discuss Youth A's arm with the parents; and the parents decided to end the session; they were upset with Youth A's behavior. The family session note indicated, Youth A became upset at this; and insisted that he would see his mother later, because he was "going to go to the hospital".

- Children hospital discharge documents that showed: Youth A had a March 16, 2015, 11:43 pm admission; and he was discharged March 17, 2015 at 6:48 AM. He was diagnosed with a "Closed Salter-Harris Type physeal fracture of the left distal radius. A surgical procedure, Closed Reduction Percutaneous Pinning left Distal Radius was done. Youth A was placed in a cast.
- Internet research data indicated the medical term for the most common type of "broken wrist" is a distal radius fracture. The radius refers to the larger of the two bones of the forearm. The end of the wrist is called the distal end; and a fracture of the distal radius occurs when the area of the radius near the wrists breaks. Physeal fractures are classified by Salter –Harris classifications, and whether the radius, ulna, or both bones are injured. Fractures occur through the growth plate. The peak age for injury to the growth plate is in the pre-adolescent growth spurt. The Salter Harris type II fracture is the most common type. The most common mechanism of injury is a fall on an outstretched hand. Extension of the wrist at the time of injury causes the distal fragment to be displaced dorsally (posteriorly). Type I and Type II displaced fractures treatment management were noted to be a closed reduction with casting.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (i) Excessive chemical, mechanical, or physical restraint.

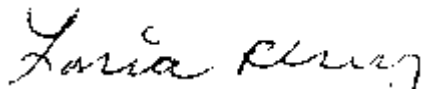
<b>ANALYSIS:</b>	<p>Youth A had showed ongoing self- harming behavior, and on the day of his restraint, which this complains addressed, he assaulted a peer, Youth B in the gym; and was aggressive and struggling during the physical management, that resulted from that altercation. All staff interviewed, who was involved in his restraint indicated he never complained of pain, or an injury during the physical management. When A he was assessed by the nurse following the restraint; he had swelling to the wrist, but was able to move his wrist and finger. A few hours later, that same day, Youth A was involved in another altercation with peer, Youth C whereby he lifted and slammed Youth C. One resident also indicated Youth A was bending his wrist to cause injury.</p> <p>The evidence does not definitively show that Youth A's wrist injury was caused by Mr. Dumas, or occurred as a result of the restraint, Youth A could have self-injured it, injured it during either of the altercations he was involved in with other residents, and thereon exacerbated it further, causing his increased swelling and pain.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4160</b>	Health services; policies and procedures.
	<p>(1) An institution shall establish and follow written health service policies and procedures addressing all of the following:</p> <p>(a) Routine and emergency medical and dental care.</p>

<b>ANALYSIS:</b>	<p>Youth A was assessed by a nurse following, the restraint on March 15, 2015; and first aid was rendered. The facility doctor was advised of Youth A's wrist swelling on the same day of the incident, and monitoring, and follow-up x-rays were ordered.</p> <p>The nursing staff assessed, and provided treated to the youth again and again, inclusive of assessing him following the youth's altercation with another peer that same day; and continued to monitor the youth, and consult with the facility doctor. X-rays were also ordered at the time of the initial notice of swelling, and were pending. Consultation with the facility doctor was ongoing, occurring at least three other times through the Pm on March 16, 2015; at which time, the doctor advised the nurse to send the youth to the ER.</p> <p>The agency was following the medical advisement of its doctor related to the youth's care; and Youth A was treated via Children's hospital the next day.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.



May 11, 2015

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



\_\_\_\_\_  
Linda Tansil  
Area Manager

\_\_\_\_\_  
Date May 13, 2015



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF HEALTH CARE SERVICES

MIKE ZIMMER  
DIRECTOR

May 23, 2015

Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2015C0420018  
Detroit Capstone

Dear Dr. Boyes:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317  
Enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2015C0420018
<b>Complaint Receipt Date:</b>	03/26/2015
<b>Investigation Initiation Date:</b>	03/26/2015
<b>Report Due Date:</b>	05/25/2015
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2014
<b>Expiration Date:</b>	09/29/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
Resident S hit staff, Ms. Burse, and Ms. Burse hit the resident back.	Yes
Additional Findings	No

## III. METHODOLOGY

03/26/2015	Special Investigation Intake 2015C0420018
03/26/2015	Special Investigation Initiated - Telephone Spoke with Director, Boyes, request incident report
03/30/2015	Contact - Telephone call made Left Message for DHS Worker
03/30/2015	Contact - Document Sent Email to Director RE: Incident report rec'd-possible missing page
03/30/2015	Contact - Telephone call received Spoke with DHS Worker
03/31/2015	Contact - Face to Face Spoke with Director, Boyes, interviewed Resident S, viewed video footage
04/02/2015	Contact - Face to Face Interviewed Resident T, Afternoon Shift Supervisor, DelShanique Beavers, And Youth Specialist, Lindsey Bennett
04/02/2015	Contact - Telephone call made To DHS Worker
04/14/2015	Contact - Telephone call made Spoke with Youth Specialist, Chez Burse
04/14/2015	Contact- Telephone call received Spoke with DHS Worker
05/15/2015	Inspection Completed- Sub Compliance

### ALLEGATION:

Resident S hit staff, Ms. Burse, and Ms. Burse hit the resident back.

**INVESTIGATION:**

Program Director, Kathleen indicated there was an incident in the facility the night of March 25, 2015, whereby Resident S hit the staff, and the staff hit the resident back. Ms. Boyes reported, the staff, Chez Burse, had, been with the facility a little over ninety days, and had just got off new hire probation; and the resident involved, Resident S had had a number of issues, inclusive of threats of harm and attacks on other residents and staff. She indicated Resident S was placed out of D.C. That Resident S had threaten to kill herself, reported to be hearing voices; has conduct issues, and, was been seen by the psychiatrist; and was on close observation, at the time of this investigation. Dr. Boyes indicated a request for replacement of Resident S was pending with the referral source; and Ms. Burse was sent home, suspended, pending investigation of this incident.

Resident S reported the incident occurred in the group room, when medication was getting ready to be passed. She said she stood at the door to get meds; and she pushed Ms. Burse, to get out the door, into the hallway; and Ms. Burse tried to restrain her. She said she got out of the restraint, and started hitting Ms. Burse in the face; that she hit Ms. Burse five to six times. She said Resident T held her back; and when she went back into the group room, Ms. Burse came into the group room and started hitting her. That Ms. Burse hit her more than once, and Ms. Burse "choked me out". She said Ms. Burse was just choking her, and had both hands cuffed under her (Resident S's) neck, on her chest. Resident S indicated she was not sure why she did what she did. She said staff; Ms. Bennett and Nurse Brown were in the hall trying to break up the fight. She indicated they had Ms. Burse. When asked if she received any marks or bruises from the incident, Resident S reported she received a scratch to the side of her face (a somewhat long healing scratch was observed to the left side of the resident's face).

Resident S, Supervisor, DelShanique Beavers, and Youth Specialist, Lindsey Bennett, all report familiarity with the incident being investigated; and all, but, Ms. Beaver reported, Ms. Burse hit/assaulted Resident S.

Resident T reported, she, Resident S, and another resident, were goofing around; and Ms. Burse told them, they all would get a violation for their behavior. Then they all saw the medication cart; and they usually get in line for their meds; but Resident S went to the door. Ms. Burse put her foot out in front of the door, so Resident S couldn't open it; and told Resident S to sit down. Resident S said she needed her meds, and Ms. Burse told Resident S to go turn off the radio; and Resident S said why her; and the two went back and with words; and each got aggravated. Resident T, said, the two didn't get along; and the day before, Resident S had spit in Ms. Burse's face. She, said, Ms. Burse then stood by the door; and got in Resident S's face," and was laughing at her , like she was egging" Resident S on; and that that's what Ms. Burse does. She, said, Resident S asked, Ms. Burse to get out of her face, then pushed Ms. Burse out of her face, and walked out the door.

Resident T, said, Ms. Burse tried to restrain Resident S, with a blind-side swoop, and Resident S tried to get Ms. Burse off of her, so Resident S started swinging, and hit Ms. Burse in the head. Ms. Burse fell down. Resident T, said, they were in the hallway at that time; and she tried to move Resident S back into the group room. She said, Ms. Burse got up; and came after Resident S, so she (Resident T) tried to push Ms. Burse away. She told Ms. Burse that Resident S was just a kid; but Ms. Burse pushed her away, and ran after Resident S. That Ms. Burse ran to the couch, went to Resident S, and started hitting Resident S; and Ms. Burse cut Resident S on the left cheek with her nails. Resident T, indicated, then Ms. Bennett, Ms. Beavers, and Ms. Tucker came in and restrained/blind-side swoop her, because they thought she was trying to jump Ms. Burse. She, said, Ms. Tucker took her to the hall, Ms. Beaver got Ms. Burse; and Ms. Bennett grabbed Resident S. Resident T, said, Resident S" is not all there, "I think she has PTSD, she's not all there."

Ms. Beavers reported hearing someone say "Bitch", she heard tables moving in the group room; saw Resident T grabbing Ms. Burse; and so she got Resident T off Ms. Burse. She, then, had Ms. Tucker to take Resident T; and she got Ms. Burse. Ms. Beavers said she couldn't see anything; she was not sure what was going on, so her initial focus was on Resident T. When asked, where Ms. Burse was at in proximity to Resident S, when she grabbed Ms. Burse, Ms. Beavers reported, Ms. Burse was behind Ms. Bennett, who had Resident S in front of her (Ms. Bennett). She said Ms. Dunlop came and took Ms. Burse to the OCC; and Ms. Dunlop and she spoke with Ms. Burse. That Ms. Dunlop wrote up the incident report; but Ms. Dunlop was not involved in the incident.

Ms. Beaver, indicated, she never saw Ms. Burse hit Resident S, not saw Resident S hit Ms. Burse. Nor did she notice any marks or bruises to Resident S after the incident.

Ms. Bennett, reported, she saw Ms. Burse trying to restrain Resident S, in the hallway, at the med cart. She, said, she did not see Resident S hit Ms. Burse, but she saw Ms. Burse fall to the floor. She indicated, Resident S went back to the group room on her own accord; and Ms. Burse followed behind Resident S, and Resident T tried to stop Ms. Burse; and told Ms. Burse, "She's just a kid, she's just a kid." Ms. Bennett, said, she tried to grab Ms. Burse, but Ms. Burse entered the room, grabbed Resident S, and "fish hooked" Resident S by putting her (Ms. Burse's) thumb in Resident S's mouth, and pulling, and tackling Resident S to the couch. She said she told Ms. Burse "She's just a kid"; and she tried to get Ms. Burse off of Resident S. She said Ms. Burse had hold of Resident S around the neck. She said, she was able to grab Ms. Burse, but Ms. Burse was punching Resident S in the face. She said Ms. Burse was on top of Resident S, and she was on top of Ms. Burse trying to pull her off; and when she got her up, Ms. Burse spanned around, and was able to hit resident S on the left side to Resident S's face two to three times. Then, Ms. Beavers came, and restrained Ms. Burse; and she (Ms. Bennett) restrained Resident S.



Ms. Bennett indicated Ms. Burse was not listening to what was been told her, "She was really really mad". When asked, if Resident S was egging Ms. Burse on, to come after her, Ms. Bennett, did not recall Resident S doing such. She, said Resident S, and Ms. Burse were both trying to get at each other. When asked, whether Ms. Burse said anything before going after Resident S on the couch, Ms. Bennett indicated, Ms. Burse said "Bitch got me Fucked up". When asked, if Resident S had any marks or bruises from the incident, Ms. Bennett reported Resident S had a two inch scratch, on her left cheek; which may have come from a finger nail or something. Ms. Bennett said, Resident S's scratch "was on the same side that Ms. Burse had fish hooked her, so it could have come from that". Ms. Bennett did not recall any marks, or bruises to Ms. Burse, but admitted she had not seen Ms. Burse since the incident,

Chez Burse, was interviewed by this Consultant, by telephone. She indicated "basically she hit me, and we started fighting. I don't really know what it was, I was trying to get a hold of her", but she knew it was not by the book.

Ms. Burse reported there had not been the type of support around for her; and that there was always confusion, as to when it was ok to send a resident to their room. She said the rules and regulations had changed daily, as to how to handle a disruptive youth, and with respect to which staff could get the resident sent for a time out if that resident was being disruptive. She, said, as a Youth Specialist, they do not get support from the Team Leader, or administration to send a kid from the group to their room, but a teacher, or Therapist can. She said consequences to the youths; especially Resident S does not work. She said this youths' behavior had been disruptive often, and when she acted out, her negative behavior spreads to the other residents, but sending Resident S to her room was not something she was allowed to do. She said the night before this incident, Resident S "spit in my face, and why they put her back with me I'm not clear on". She said then the next day, "they split the group (Group E) up", but they put Resident S, Resident T, and two other residents, who had been in the room, when Resident S spat on her, with her. She, said earlier in the day, Ms. Bean had walked out of the group, due to Resident S's acting out, and, Supervisor Ms. Beavers' lack of assistance; and then they brought Resident S back to the group; and subsequently this incident occurred.

Ms. Burse, said, Resident S, Resident T, and another resident were not following directions. Resident S was throwing her snack bag, doing things, and she had to constantly redirect Resident S. Then the med cart came, and Resident S jumped up and came to the door. Ms. Burse said "I put my leg out to the door" and reminded Resident S of the procedure for medication pass; and Resident S started cursing, and telling her she "ain't doing shit", and she better get out of her face. She said, she told all the residents to turn off the radio, if they wanted to be first in line, or no one gets their meds, if they don't. She said Resident S ran to the door, she thought Resident S was going to stop at the door, so she opened the door, leaned against it, and instead of stopping, Resident S pushed forward, and said, "Get the fuck out of my way." Ms. Burse, said, she grabbed at Resident S's collar, and tried to pull her

back into the group room; and told her that's not procedure; then Resident S swung her arm back at her. She said, Resident S swung so hard, that she (Ms. Burse) lost her balance. She said, "I guess, she realized I didn't have her anymore", and since she lost her balance, Resident S swung, and she (Ms. Burse) went down. She said, Resident S "was trying to connect; and when she did, I said, what the fuck." Ms. Burse said, she thought she was going to get to restrain Resident S, "but when I did that" Resident S swung, and hit her more. She said, "It was like I was fighting."

Ms. Burse was not sure who broke the fight up. She said, once she got some where away from the area, "I just left the building". She said, when Ms. Beavers saw video of the incident; Ms. Beavers, said, "I should have called her" when Resident S threw the snack bag on the floor. Ms. Burse indicated why would she, when just recently that same day, nothing occurred, when it was asked that Resident S be removed, due to Resident S's behavior. When asked, did Resident T try to intervene, or assault her, Ms. Burse, could not recall what Resident T did. When asked, if she had been suspended, or terminated, Ms. Burse was not sure, she indicated she had not heard from the agency, since Ms. Brown called her, minutes after the incident.

#### **Reviewed:**

Incident report, dated March 25, 2015, completed by Ms. E. Dunlop that indicated:

- During PM medication pass, Resident S became upset, when staff directed her to turn the radio off. Resident S became aggressive and pushed pass the staff to exit the room. Staff attempted to physically managed Resident S; and Resident S physically assaulted staff, by punching her several times in the head; in retaliation, the resident was struck back. Assistance was called to separate the resident and staff, the supervisor, and nurse on duty were called; and children service notified.

A March 26, 2015, 2:23 AM email nursing note from, Tyrone Brown, LPN, to the nursing, and administrative staff. The nursing note indicated:

- He assessed Resident S, at 6:45 PM, due to her having a long scratch, with minor bleeding to the left side of the face. That the area was cleaned, and treated, no other bruising, scratches, swelling, or injuries were observed; and Resident S was able to perform active range of motion, with both upper extremities bilaterally, with difficulty or pain.

Video footage, which showed:

- The lead up to the physically incident between Resident S, and Ms. Burse: Resident S, Resident T, and other residents playing around, throwing a bag, pushing chairs, and moving about, Resident S going to the door, Ms. Burse sticking her leg out, as to block the resident from moving forward to the door, then Ms. Burse standing at the door; and she and Resident S appearing to talk back and forth.
- Resident S pushing pass Ms. Burse; and Ms. Burse grabbing Resident S, and had the youth's arm behind her; and Resident S pushing Ms. Burse, hitting her, and them moving out of the door, and into the hallway. Then, Resident S

struck Ms. Burse in the head several times, the two struggled/move about; and Ms. Burse sort of went down to the floor. Ms. Burse got up tried to go after Resident S, and Resident T appeared to grab at Ms. Burse. They go back into the room, Ms. Burse ran after Resident S, get Resident S on the couch, and strikes Resident S at least three times; and had Resident S in some sort of headlock—Ms. Burse appeared to have her elbow around Resident S's neck.

- Resident T tries to interfere or intervene by pulling at Ms. Burse. Ms. Bennett appearing behind Ms. Burse, and Ms. Beavers intervening, moving Resident T out of the way. Then Ms. Beavers grabs Ms. Burse; and Ms. Bennett grabs Resident S.

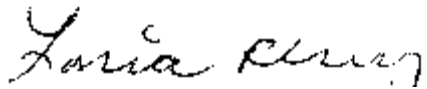
<b>APPLICABLE RULE</b>	
<b>R 400.112</b>	<b>Staff qualifications.</b>
	A person with ongoing duties shall be good moral character, emotionally stable, and of sufficient health, ability, experience, and education to perform the duties assigned.
<b>ANALYSIS:</b>	<p>Ms. Burse was frustrated with Resident S' negative behavior, and what she perceived as a lack of support, from supervisors, and the administration, to her, and other Youth Specialists in dealing with Resident S's behaviors. She did not call for supervisory assistance, when Resident S began to act out, because she did not trust, what she believed to be, beneficial assistance would be provided her.</p> <p>She was trying to restrain Resident S, and when Resident S hit her, Ms. Burse reacted, and fought the resident back. She acknowledged her interaction with the resident was not by the book.</p> <p>The staff actions, demonstrated an inability, and insufficient degree of experience to perform the duties assigned.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	<p>(2) An institution shall prohibit all cruel and severe discipline, including any of the following:</p> <p>(a) Any type of severe physical discipline inflicted in any manner.</p>

<b>ANALYSIS:</b>	Resident S attacked, staff, Ms. Burse, hit her in the head several times; and knocked her off balance. Ms. Burse went after the youth, in an attempt to restraint her, but in the course of the physical management, and or as a result the assault on her person, attacked Resident S, placed her in a headlock, struck her several times, and ended up scratching her face.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, continuation of the facility current licensing status is recommended.

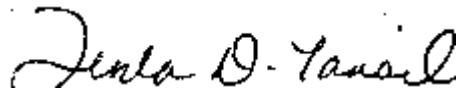


**May 22, 2015**

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



Linda Tansil  
Area Manager

\_\_\_\_\_  
Date May 23, 2015



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF HEALTH CARE SERVICES

MIKE ZIMMER  
DIRECTOR

June 10, 2015

Kathleen Boyes  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2015C0420022  
Detroit Capstone

Dear Dr. Boyes:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF CHILDREN AND ADULT LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2015C0420022
<b>Complaint Receipt Date:</b>	03/30/2015
<b>Investigation Initiation Date:</b>	03/30/2015
<b>Report Due Date:</b>	05/29/2015
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2014
<b>Expiration Date:</b>	09/29/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
Agency Director, reported two residents (Resident A and Resident C) AWOLed last night and only Resident A had been returned.	Yes
Resident A alleged he was mistreated by staff, as reason why he AWOLed.	No
Additional Findings	Yes

## III. METHODOLOGY

03/30/2015	Special Investigation Initiated - Telephone Spoke with facility Director, K Boyes
03/31/2015	Special Investigation Intake 2015C0420022
03/31/2015	Contact - Face to Face Spoke with Director, Boyes, Environmental Service, Director, Danny Williams, interviewed, Resident B, Resident A, and Youth Specialist, Antonio Dumas
03/31/2015	Contact - Face to Face Resident A alleged staff choked him out, chicken winged him, and hit him in his ribs, Staff, Mr. Harden, Mr. Hill, Mr. Belton and Mr. Dumas name. Informed Director of allegation. Director reported children service referral had already occurred
04/01/2015	Contact - Document Received Email from Mr. Williams Re measures being put forth to ensure security due to recent AWOL
04/02/2015	Contact - Face to Face Interviewed Youth Specialists, Isaiah Livingston, Antonio Hill, Corey Harris, Midnight Shift Supervisor, Tromone Guyton, and Afternoon Shift Supervisor, Leonard Harden
04/14/2015	Contact - Telephone call made Message left for Youth Specialist, Jazmon Belton
04/15/2015	Contact - Telephone call made Spoke with Youth Specialist, Jazmon Belton
05/28/2015	Inspection Completed-BCAL Sub. Compliance



**ALLEGATION:**

Agency Director, reported two residents (Resident A and Resident C) AWOLed last night and only Resident A had been returned.

**INVESTIGATION:**

It is noteworthy that this complaint was also received on-line on March 31, 2015, after the facility self-reported the AWOL; and after this Consultant had spoken with Director, Kathleen Boyes, and interviewed Resident A and Resident B. The on-line complaint indicated that on March 27, 2015 staff observed that Resident C and his roommate Resident A had tampered with their window and the residents admitted to the incident. The residents' room was changed; and on March 29, 2015, both broke the window in their room, jumped out, and staff retrieved them, and changed their room again. Then, at 2:30am on March 29, 2015, the residents destroyed the window in their room, and AWOLed out of it.

Director, Ms. Boyes, indicated, on the midnight-shift, Resident A and Resident C AWOLed; and Resident C still had not returned to the facility. She, indicated, neither Resident A nor Resident C had been a problem at the facility; and they would have been the last kids, she thought would do something like this. She, indicated, the two residents had jimmy opened a window in their bedroom, which was on their first floor, and jumped out. She, indicated, Resident B was in the room, but he did not AWOL. She, indicated, Mr. Williams was working on redoing the beds and windows to correct whatever problem there was with those items.

Environmental Quality Assurance staff, Danny Williams indicated he was redoing the beds and windows in rooms. He indicated the boys were able to get a bracket that held the bed into the concrete, and they used that bracket to jimmy the window. He speculated that the boys kept pushing the bed, to move it, and that enabled them to remove the bracket. He, indicated, the boys were able to jimmy away at the steel around the window to remove the plexi-glass. And once that was done, they were able to peel out the steel, and push the window hard enough to get it out. He, indicated, the incident would have had to have been planned; as getting the bracket loosen, would have happened over a period of time.

Mr. Williams indicated the facility is on a three to four security level and they plan to upgrade. He indicated the new beds are all bolted to the floor.

Resident B (14), at the time of his interview, reported, being at the facility for two months. He indicated, being Resident A, and Resident C's roommates, and being present when the incidents occurred. He, said, Resident A and Resident C used the latch off of the bed to pry the window open; and that it took them about forty-five minutes, to an hour, to pry the window out. He indicated they had "messed with the bed all day to get the bracket off, but they didn't start messing with the window until he went to sleep. He said the midnight shift staff had been on duty about thirty minutes, to an hour, when they started on the window; and Resident A and Resident

C worked around the staff's ten minute rounds. He named, Ms. Thomas, Mr. Guyton and Mr. Livingston as the staff working that shift; and indicated Mr. Livingston was in the hall. He said, Ms. Thomas would cut on the light and look through their door; but Resident A and Resident C would hear the click of the light, and would then get back in their beds. When asked, whether staff come in the room, to check on them, Resident B, indicated, the afternoon shift staff will come into the room, and sometimes midnight staff come into the room, but mostly the midnight shift staff just turn on the light, and check. He, said, both Resident A and Resident C "take sleeping meds, so staff may have thought they were sleeping". He, said, Resident A and Resident C got out their window at about 1:30 AM, they were in the back area where the central air is, and that area is gated and meshed, where you can't see how to climb the fence. He, said, Mr. Livingston saw them, that "Mr. Livingston was in the hallway, and I heard Mr. Livingston ask Mr. Guyton did you hear that". He, said, there is a room before their room, and Mr. Livingston may have seen Resident A, and Resident C through that room's window. Then, Mr. Livingston, Mr. Harris, and Mr. Guyton came into the room, and they saw that the window was off, and that only he was still in the room. When asked, if the staff came into his room, and asked him any questions, about how Resident A and Resident C got the window out, Resident B, said "No because they caught them". He, said, they didn't have any place to go. Resident B, indicated, the staff placed him in the group room, and Resident A and Resident C were also there, while they (staff) got another room ready for them. He, said, they also had Resident A and Resident C assessed by the Nurse.

Resident B, indicated, he, Resident A, and Resident C were all placed in another room, which was down the way from the prior room, on the Matrix hall /Group M hall. He, said, after they were in the second room; he went to sleep; then at about 2:30AM he heard banging, which he said was Resident C hitting the ground. And he saw Resident A on the window getting ready to jump. Resident B said, he banged on the door; and told staff "They're jumping out the window". When asked, whether Resident A and Resident C pried the bracket away from the bed, in the new room, to use to it to remove the window, Resident B, reported, the new room had a new beds that are bolted.. He, said, Resident A and Resident C used the bracket from the old room. When asked how he knew this, Resident B, indicated, because he saw the medium side bracket on the floor; "they dropped it on the floor".

Resident A (15), at the time of his interview, reported being at the facility for three months. He, reported, he tried to escape because he was being mistreated by staff. (Investigative information pertaining to the alleged mistreatment is addressed later, in this report). Resident A, indicated "on March 13, I got chicken winged" by Mr. Harden, and Mr. Hill upstairs in his bedroom, because he had tried to escape. He, said, he cracked the window, in his room, with a metal bracket, that he got off of his bed, in another room, that he had tried to escape from. Resident A, said his room was changed; and he received a consequence for breaking the window.

Resident A, said he escaped two days ago (prior to this interview) on March 29, 2015, after midnight. He said he got two metal brackets off of the bed, and “I popped the window, then I popped the other window out”; and he jumped out. He, said, they were on the first floor, so it wasn’t a high jump. When asked how he got the brackets off the bed, which were concreted into the wall; Resident A reported, he lifted the bed several times, until it loosened from the wall, then grabbed the bracket bar, and straighten it. When asked wouldn’t that have made a loud noise, he indicated it was loud, but he was doing it quietly. He, said, he put a book under the bed to make it incline, and easier to pop off the wall; and it took about fifteen to twenty minutes to get off the brackets off. After he got them off, he used the bar to pop off the black metal part that went around the big window, bent the other two sides, and stuck the bar under the rubber part, and he was able to pop out the window. He, said, “Once we moved the rubber off the second window, we pushed it, it popped out, but it didn’t fall, we grabbed it, sat it down and jumped out. He, said, five to ten minutes later, Mr. Guyton, and Mr. Livingston happened to walk down the hall, and they saw them outside through a window. Resident A, indicated, he and Resident C were not able to get off the grounds; they were behind the basketball court and were unable to get outside the facility grounds. He, said, staff came and got them; then switched their room.

When asked if someone else helped him, he, said, Resident C “helped me carry the window’, to set it on the wall by the bed, so staff couldn’t see it when they did rounds”. Resident A, said staff did rounds every fifteen to thirty minutes, but he couldn’t remember the names of the midnight staff. He, said, those staff never came into the room to check on them; the staff turned on the light, looked in to make sure he was laying down; and he was, because he was checking on them(staff) by looking out his door window. And, if he saw staff, he and Resident C got back in their beds. He, said, Resident B “did nothing, he (Resident B) was trying to sleep, but we were making too much noise”.

Resident A, reported, when staff switched their room, he and Resident C popped that room window and escaped. He, said, staff did about three rounds, before he and Resident C escaped; that he and Resident C took turns and “were messing with the window” in between every round the staff made. When asked, how he and Resident C were able to pop the window in the new room, Resident A, said they used the brackets from the other room, which Resident C hid in his mattress. When they carried their beds over to the new room, they took the brackets out; and one was dropped in the yard. He said staff, didn’t check their beds.

Resident A reported his dad reported him to the facility; that afterward he went to mom’s house in River Rouge, she called his dad. When asked, when he returned did someone speak with him about how he escaped, he said, no one asked him how he did it. He, indicated, he was told his consequence.

Youth Specialist, Isaiah Livingston, employed at the facility since 2005, acknowledged working the midnight shift the day of the incident. He, indicated,

when he came on shift, the supervisor, Mr. Guyton informed him some kids were still up. He, reported, he was monitoring the long hallway area on the unit, so he tried to monitor for the residents that were up, by getting near their rooms. He, indicated, Ms. Thomas, and Mr. Harris were also on the floor/unit. He didn't know what Mr. Harris was doing. He, said, Ms. Thomas was doing rounds, and then he heard a thump. He got up, and saw two boys, (whose names, initially, he did not recall) outside, through a window from the first room. He ran to the second room, and saw that the window was gone; and he called Mr. Guyton. He, said, the second pane of the window, was sitting in the room, on the side wall near, the bed and the cabinet. Mr. Livingston, indicated, he stayed in the room; and watched at the window while Mr. Guyton got the boys. He said, where the boys had escaped to, was gated, there was no place for them to go; so when Mr. Guyton retrieved them, they were sitting by the gate. Mr. Livingston recalled the incident happening between midnight and 12:30AM. When asked, if he saw any type of tool, or bracket that the boys may have used to get the window free/out, he said, no.

Mr. Livingston, indicated, Mr. Guyton took Resident A (whose name he now recalled), Resident B, and Resident C (whose name he never called) into the group room, where Mr. Livingston monitored them while the nurse assessed them. Thereafter, Mr. Harris relieved him, he went to fold towels, and a short time later he heard knocking. He went to investigate, where the knocking was coming; and found Resident B standing in from of the door in his (Resident B's) room; and Resident B, said "they left". That Resident A and Resident C had escaped from the new room they were moved to. He, indicated, the new room was on the opposite hall/the short hall, whereby when they were outside they were able to somehow exit the grounds. He, said he, and Mr. Guyton checked the grounds, and could not find Resident A and Resident C.

When asked, if the residents were searched after the escaped from the first room, Mr. Livingston said "No not that I recall". He, said, all the boys had on was a t-shirt, nylon pant/bottoms and sandals; and Resident A had a partial cast on his foot. He, said, he did not help Mr. Guyton move the boys to a new room, nor did he know where the boys were moved to. Mr. Livingston acknowledged the boys took their mattresses from the old room to the new one. And, when asked if there were any brackets found after they escape,, Mr. Livingston indicated two or three brackets were found underneath the hard plastic bed post of one of the boys' beds (he was not sure which). Mr. Livingston was not sure how many of the brackets had held the beds, nor did he know what happened to them. He, said, "I didn't grab them", Mr. Guyton grabbed the brackets, looked at them and sat them down. He indicated, not knowing at that time, that the bracket had been used as means of escape; he, said, Mr. Guyton told him that later.

When asked if any special precautions or attention was placed on the three residents after the first escape, Mr. Livingston was not sure. He indicated "I didn't know where they were placed". He said, he continued to monitor the long hall area, after the boys were moved to another room; because he was needed there. He, said

some residents were still up. He, said "No one asked me to go to that side to put special attention on those boys". He, indicated, he was not doing rounds prior to the incidents, but rounds were being done. He, indicated, there is a "key light"/switch on the outside of the residents' door, which allows staff to turn on the light and look into the room to check on them. When asked if residents can hear staff when they are turning on the switch; Mr. Livingston, indicated, the switch does make a noise, and the kids probably hear staff walking to the door. He, indicated, when the facility did not have the light switches, staff opened the door and looked in. He, indicated, prior to him hearing the thumb, he heard the usual playing, laughing, and up and about activity, of the residents, for a Saturday. He, said, he sat by the room of those three residents, because "those kids seemed more suspicious", they were watching the door way and watching to see who was doing rounds. When asked, if he mentioned his suspicious to anyone else, Mr. Livingston, did not. He, said, "they saw that the kids were still up"; and Mr. Guyton had told him the kids were still up. Mr. Livingston was not sure, who contacted the police about the boys escape, but suspected the Operation Control Center (OCC) did so.

Youth Specialist, Corey Harris, indicated, his shift started at 11:00PM; he was on laundry, and Ms. Thomas was doing rounds. He reported during the shift, Resident A and Resident C; attempted to AWOL. That the residents broke the window, used something to pry out the window, and got out. That the residents were in the court yard, by the basketball nets; and Mr. Livingston contacted Mr. Guyton about it. When asked, what he witnessed; Mr. Harris indicated he heard a commotion over the radio, he responded, went into the room; and saw the kids outside. He, said, Mr. Guyton was in the room; Mr. Guyton directed Resident A, and Resident C to come back inside. The boys weren't coming back; so Mr. Guyton went outside and got them.

Mr. Harris, reported, after Mr. Guyton found the boys, Mr. Guyton took them, along with Resident B, into a group room; and Mr. Livingston was with the boys in the group room. He, said, he was instructed to take over supervision of the boys until Mr. Livingston came back; but Mr. Livingston never did, and fifteen minutes later, Mr. Guyton transported, all three boys to another room, on the short hall/ Horizon hall, which was close to the street.

When asked, when the boys left the room did they have, or get their things, Mr. Harris, indicated, Mr. Guyton instructed the boys to get their things, along with their mattress/cot. When asked, if the kids, or their belongings, were searched, Mr. Harris, indicated, he did not think so. He, said, after that, he proceeded to do rounds. He, said, he turned Resident A, Resident B, and Resident C's room light on in the new room, because of the prior attempted AWOL; but sometime later, just before he took a bathroom break, Mr. Guyton told him to turn the residents' light out, so the boys could rest. At about 2:30AM; Mr. Harris, said, he told Mr. Livingston, he needed to take a bathroom break; so Mr. Livingston went to the short hall, so as to check on the three residents; and to fold clothing. Mr. Harris, said, when he

returned, five minutes later, Mr. Livingston reported Resident A and Resident C had AWOLed again.

When asked, if there was a check on the boys, before the lights went out, in the new room, Mr. Harris, indicated, there was, that he had gone into the boys, room. He said, they were in bed, but not asleep; and he had not noticed anything unusual. He, said, the residents new room was one whereby the beds were not bolted to the wall. He, said he checked the window, and it was intact, no problem. Five minutes later, he checked the residents room again, went inside, and there was no window on the floor, no problem with metal on the window; nothing looked pried. He, said, after Mr. Livingston told him the boys had left again, he went into the room, the boys were gone; and he noticed an object that looked like a metal object from the bed, on the bed. He, said, he knew that object couldn't have come from the new room; because the new room had new beds; which are installed differently; and so this was why he didn't believe the residents had been searched. He said, Mr. Livingston notified, Mr. Guyton of the new AWOL, Mr. Guyton went to search for the two residents; and he continued doing rounds; and thereafter opened every door to check on the residents.

When asked, whether anyone talked with Resident A, and Resident C, after the boys tried to escape, the first time, Mr. Harris, said he did, while the boys were in the group room. He, said, the boys mentioned prying open the window during the afternoon shift (3:30PM-11:00PM); and that the window was already out when Mr. Harden came on; and the window was pushed over to the side, against a wall to the right side of the room. Which, per, Mr. Harris, would make it not visible, when one looked into the room. Mr. Harris, said, the boys did not say what they used to pry the window, and he did not ask; but "pry" was the word they used. When asked, thinking back, whether he thought there were any red flags, related to this incident, he did not. He said prior to the boys first AWOL attempt, the night had been quiet. He did not think there was an unusual amount of residents, up and about, on the shift.

Shift Supervisor, Tromone Guyton, acknowledged that Resident A and Resident C escaped from the facility twice. He indicated the first incident occurred between 12:45 and 1:00AM. He, said, all the kids were pretty much up. Ms. Thomas was doing rounds between 11:00PM and 1:30AM; and Mr. Livingston was posted on the Matrix hallway (long hall) to listen for noises, and to de-escalate, a situation that may occur. He, said Ms. Thomas, and Mr. Livingston heard a noise. Mr. Livingston entered Resident A, Resident B, and Resident C's room, and observed a portion of the window gone; Resident B was in the room; and Resident A and Resident C were gone. He, said, Ms. Thomas got him; and he noticed that a piece of the window was missing. He, said, the big piece of glass was in the room, hidden, by it lying on the wall; it was not shattered or broken. He, said, two brackets that had come from the bed were on the floor. He, said, a bracket was used as a crow bar; and the kids used it to crack the window out.

Mr. Guyton, stated, he jumped out of the window; and found Resident A and Resident C hiding out. He, said, there was no place for the boys to go, they were still gated in. He, said, when they got the boys, he brought them back in, by climbing through the window. He took the boys to the group, until the nurse could assess them; because, he said it was not safe for them to go back to their room. He indicated the boys had their things, mattress, pillow, clothes; and other things, (depending on their level) with them. He said, he had Mr. Livingston "sit on them for about ten to fifteen minutes" then switch in Mr. Harris, while they assessed the situation, and he could find another room for the boys. When asked, whether Resident A and Resident C were searched, Mr. Guyton, stated "I told my staff to search them, but I don't believe they did; so I'll take responsibility for that". He called, Ms. Brown (Program Coordinator) about the incident, informed her he was moving the boys. After he placed the kids in the new room, he talked to them for about ten to fifteen minutes regarding what happened; and he left. He, said, the boys were worried about their consequences. When asked, whether Resident A, and or Resident C, told him how they got the window out, Mr. Guyton indicated they did not. When asked whether he asked them how; he said, "No"; he said at that point he was just trying to calm them, so they could go to sleep. He, said, Ms. Parham was placed on the short hall (where the boys' new room was located) temporarily for about a half hour. That Mr. Harris round started about 1:30 AM (to run until 4:30AM).

Mr. Guyton, reported, at about 1:34 AM; Resident B, got in touch with Mr. Livingston by knocking on the door, and letting him know Resident A, and Resident C were gone. When he checked the room (new room), he observed that a part of the outside window was pushed out. The big glass window was inside the room, on the floor, and one bracket piece was on the floor. When asked whether that bracket piece was from the other room; Mr. Guyton said, "it had to be", because the beds in this room (the new room) didn't have to be mounted to the wall. He said, at that point, the OCC had called the police, and Ms. Brown; and he, and Ms. Thomas did a community search. They ran into the police, but Resident A and Resident C were not located.

When asked whether it was protocol to search a resident, after an AWOL, Mr. Guyton said "Yes". He, indicated, the window the kids escaped from are new three pane ones that were installed in the building sometime earlier this year. He, said with the old windows, they could be cracked, but there was no way, one could physically remove them. When asked, if there were any red flags related to the incident. Mr. Guyton indicated there had been an incident the day before, whereby two residents in the room next door had tampered with a window and damaged it somehow. He said, the only strange thing the night of this incident, was the number of residents that were up and about, banging on doors, etc.

Afternoon, Shift Supervisor (3:00PM -11:30PM), Leonard Harden reported having no information pertaining to Resident A and Resident C's escape from the facility on March 29, 2015. He, indicated, noticing nothing unusual with Resident A, Resident B and Resident C during his shift; and his staff did not report anything. When asked

whether staff would have gone into these residents room, for any particular reason, during that PM shift, Mr. Harden indicated, no.

When asked if there had been another day whereby Resident A had, done something to a window in his room, Mr. Harden recalled a day Resident A had. He, said, while during rounds, a staff (whom he could not recall) noticed a window was cracked; and he (Mr. Harden) checked it out. He, said, he noticed the inside window pane was removed and hidden against the shelves, and the wall. He said the shelves are pressed against the wall, so staff looking through the door, or stepping in the door, wouldn't see it, unless they walked further into the room. Mr. Harden reported he consequented Resident A, and the other resident, Youth 3 (for purposes of this report); contacted Ms. Brown, maintenance; and moved the boys to another room. When asked, whether he asked Resident A how the window was taken out, Mr. Harden, said both boys said they took brackets from the bed, and used it to pry the window casing from the window enough to loosen it and take out the front windowpane. When asked how many brackets there were, Mr. Harden, indicated, there was one bracket, and he took it. He said, there was another bracket on the wall, but it was completely screwed into the wall. When asked whether Resident A, and Youth 3 said how they got the bracket out of the wall; Mr. Harden, indicated, they said, they just messed, and pried, with it, until they pulled it off.

When asked where Resident A and Youth 3 were moved to, Mr. Harden indicated, upstairs, to the Horizon side, by the court yard. He said, the boys stay in that room for a couple of days; then they were moved down to the Matrix hallway, because a new resident arrived. He said Resident A and Youth 3 were placed in separate rooms/where beds were open. Resident A went in with Resident B, and Resident C. When asked whether staff checked that room to verify whether the beds were mounted via brackets to beds, like they were in the room Resident A moved from, Mr. Harden, stated, "I wasn't a part of the move". When asked if it was protocol to search a resident, and his personal belongings, if the resident AWOLs; and when the resident moves from one room to another; Mr. Harden reported, yes, to both questions. He, indicated, when moving Resident A(related to the cracked window incident); we found two pieces of the windowpane wrapped in a sheet in the mattress pad.. He reported completing an incident report about the matter; and he affirmed that the next shift supervisor should have been got the incident report. He, indicated, "I let them know".

Mr. Harden, indicated the time between the crack window incident, and the incident whereby Resident A actually escaped, was about two weeks. When asked whether precautions would have been put in place, since the facility knew the two residents had done what they had, with the brackets and the windows, to try escape, Mr. Harden, indicated the precaution he took was to move the boys to another floor. He said, he put them on the inside room, whereby they faced the court yard. He, said, the room Resident A and Resident C escaped from faced the street.



It is noteworthy, that a March 13, 2015 incident, (reported for 5:30PM, Matrix program), pertaining to Resident A, was provided this Consultant. It indicated "While doing rounds, staff noticed the window in room 110 was broken; and Resident A admitted he and Youth 1 broke it. That incident report listed Youth 3 as the other resident present; and Mr. Hill as the staff present. It indicated, "The residents were searched, and a room change was administered to avoid further incident". The incident report made no mention of brackets being found, or window pieces being found in a mattress. The incident report was signed off by Team Leader, E. Dunlop; and it indicated maintenance was notified.

#### **Reviewed**

- Incident report dated March 29, 2015, 2:30 AM for Resident A.
- Nursing incident forms dated 3/29/15, 12:40AM, for Resident A and Resident C, with nursing note.
- The facility's resident location search policy.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(2) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS:</b>	<p>Resident A made at least to two failed attempts to escape prior to doing so on his third try. Staff knew about each failed attempt; one, which, occurred approximately two weeks prior to the second attempt; and the second attempt, whereby he and Resident C tried to AWOL occurring less than three hours, prior to him and Resident C escaping on his third try.</p> <p>The facility and its staff were aware of the failed AWOL attempts; and of a tool or brackets from a bed being used by the residents to pry out the window; but no extra precautions were put in place to further supervise, protect and safeguard the residents.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4109</b>	<b>Program statement.</b>
	<p>(1)An institution shall have a current written program statement which specially addresses all of the followings:</p> <p>(c) Policies and procedures pertaining to admission, care, and discharge of residents.</p>

<b>ANALYSIS:</b>	<p>Resident A made to two failed attempts to escape, prior to doing so on a third try. Two weeks prior to his escape, he had broken his window; and parts from the window were found in Resident A or Youth 3's, mattress; and a bracket was also found. Resident A attempted to escape a second time; and he and Resident C used brackets from the bed to take out the window in their room; yet when the two residents were moved to another room; they, their mattresses, and personal belongings were not searched; and a bracket, which had been concealed in a mattress/one of the resident's belongings, was used to pry out and remove the window, in the new room; and that enabled the two residents' escape.</p> <p>The facility did not follow their protocol to search Resident A, Resident C, and their belongings, after they AWOLed, and when their room was changed. Not doing so hindered staff from locating the brackets; and possibly averting the residents' escape.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### **ALLEGATION:**

Resident A alleged he was mistreated by staff, as the reason why he AWOLed.

#### **INVESTIGATION:**

Resident A (15), at the time of his interview, reported being at the facility for three months. He reported he tried to escape because he was being mistreated by staff. When asked how was he being mistreated; and by whom; Resident A indicated he was being "chicken winged" by staff. He, indicated, a "chicken wing" was a restraint hold whereby your arms are pushed up behind your back up to toward your neck. He, said, he had also been hit in his ribs, he had gotten choked twice, whereby he couldn't breathe; and his arm was pushed upward "barred" out like in a bench press maneuver. He said Mr. Harden, Mr. Hill, and Mr. Belton did this. When asked, what staff did what, and when; Resident A, reported, the first time he "got choked out" and his arms barred, was by Mr. Belton and Mr. Dumas, a few days, to a week after he first got to the facility. He, said he was in his room arguing with a roommate, Youth1 (for purposes of this report); and Mr. Belton and Mr. Dumas came in, and choked him by putting an elbow around his neck. When asked whether the staff was trying to restrain him, Resident A said "I don't know they just came in, and tried to" chicken wing me", and tried to push his arm up, but didn't do so. He, indicated, Youth 1 was not in the room, when the incident occurred, but another resident, Youth 2(for the purposes of this report) who is no longer at the facility, was. He, said, Mr. Belton slammed him; and Youth 2 got hit in the back of the head, because Youth 2 was being bad. He, said, he couldn't remember when this incident happened, but it was a while ago. He, said, he never told anyone about this incident because "I was scared they would do it again if I told". Resident A, reported," Then on March 13, I got chicken winged" by Mr. Harden, and Mr. Hill

upstairs in his bedroom. He, reported, he was attacked because he tried to escape, by cracking the window with a metal bracket that he got off of his bed, in the other room, that he had tried to escape from. He said, when the two staff “chicken winged” him for breaking the window, “I felt like my arm was going to break, I couldn’t feel my arm for five minutes, after they let go.” Resident A, said, he told his dad about this incident, after he escaped, and went home.

Youth Specialists, Antonio Dumas, Antonio Hill, and Jazmon Belton, as well as, Afternoon Shift Supervisor, Leonard Harden all acknowledged familiarity with Resident A; and all denied the allegations reported against them.

Mr. Dumas could not recall Resident A and Youth 1 sharing a room, but he couldn’t say for sure that they never did. He, said, he had never restrained Resident A, he barely ever worked with Resident A’s group; and that he had never choked, bar held, hurt or chicken winged Resident A, or any resident.

Mr. Hill, reported, Resident A is a “mild mannered kid”. He reported he had never restrained Resident A, nor to his recollection, had he had to escort or place hands on Resident A in any way. He denied knowing what a “chicken wing” was, but acknowledged having heard residents say they were “chicken winged”. He indicated he never put Resident A’s, or any kid’s arm or arms behind their back and pulled them upward. And that he never choked Resident A, hit him in the ribs, or observed any other staff do, so. He didn’t recall a time Resident A cracked his (Resident A’s) window with a bracket, but indicated he knew, now, that kids were taking the brackets off of their beds. He denied that he ever threatened Resident A because Resident A was trying to escape, by cracking his window with a bracket.

Mr. Belton reported a cordial relationship with Resident A; one whereby he had rarely had to redirect Resident A. He, said, Resident A never caused a problem; and the resident had come to him with various issues. When asked, if he ever restrained Resident A, Mr. Belton admitted he had once, because Resident A and his room were in an altercation. He recalled that incident, as a quick intervention, whereby, the two residents were separated; and one was escorted to the Behavior management room. Mr. Belton could not recall if Youth 1 was the other resident involved in that incident.

Mr. Belton, denied knowing what a “chicken wing” was, and denied he, and Mr. Dumas did such to Resident A. He reported Mr. Dumas was the staff, he had usually worked with; but indicated, at the time that he had worked with Mr. Dumas, Resident A was not yet a resident at the facility. He indicated, Mr. Harden was his supervisor; and he denied ever observing Mr. Harden, Mr. Hill, or Mr. Dumas being inappropriate with Resident A or any resident.

Shift Supervisor, Mr. Harden, had heard of a “chicken wing”; and he indicated, he and Mr. Hill did not do that to Resident A. He indicated, Mr. Hill worked that shift, (the day Resident broke the window) as a Floater (going where he was needed), but

Mr. Hill did not work with Resident A. When asked if Resident A was restrained that day, Mr. Harden reported, no, because Resident A wasn't caught breaking the window. He, said, hands were not put on the youth that day. That staff only removed Resident A and Youth 3 from the room, "No hands on them, and they carried their own stuff". Mr. Harden, indicated Resident A to be a pretty good kid, a resident he talked to daily. He, reported, being unaware of where these allegations were coming.

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of severe physical discipline inflicted in any manner.
<b>ANALYSIS:</b>	The evidence does not support the allegations
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan, continuation of the facility's current licensing status is recommended.

**June 8, 2015**

\_\_\_\_\_  
Lonia Perry Date  
Licensing Consultant

Approved By:

**June 10, 2015**

\_\_\_\_\_  
Linda Tansil Date  
Area Manager



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF HEALTH CARE SERVICES

MIKE ZIMMER  
DIRECTOR

July 30, 2015

Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2015C0420035  
Detroit Capstone

Dear Dr. Boyes:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
Bureau of Children and Adult Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF HEALTH CARE SERVICES  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2015C0420035
<b>Complaint Receipt Date:</b>	05/11/2015
<b>Investigation Initiation Date:</b>	05/20/2015
<b>Report Due Date:</b>	07/10/2015
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2014
<b>Expiration Date:</b>	09/29/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
Staff have bumped into Youth 1 to antagonize her.	No
Staff is "Highly unprofessional", they gossip among each other, and kids. Personal information is shared with other residents by staff; and staff make fun of residents' situations, by talking about their mothers, saying that "they sell their pussy". And that staff make statements about the residents, such as that they are 15/16 years old and don't know how to "wash their asses", and tell residents to go tell their mama, "cause I'll whoop her ass too".	No
Youth 1 has been attacked twice, and has not hit back; it is not clear if this was by a staff or another resident.	No
Staff refused Youth 1's request to call her therapist, during or after business hours; and two written grievance have not been addressed.	
Youth 1's mother has no means of transportation for visits, and the agency has not assisted with visitations.	No
Youth 1 was prescribed medication without being informed what it was.	No
The residents always run out of hygiene products, and were out for three days.	No
The facility electricity was out on 3/29/2015; and residents missed one meal. The residents are fed apples, and bread with mold on them.	No
Huge roaches are in the facility, and come out of the vents. And the showers flood, and are not clean.	No
The showers flood, and are not clean.	No
Residents have not been able to do physical activities because they do not have shoes for gym.	No
Additional Findings	Yes

## III. METHODOLOGY

05/11/2015	Special Investigation Intake 2015C0420035
05/20/2015	Special Investigation Initiated - Letter Email sent to Director K. Boyes RE Complaint
05/28/2015	Contact - Telephone call made Spoke with Complainant
05/28/2015	Contact - Face to Face Interviewed Youth 1
05/29/2015	Contact - Face to Face



	Interviewed Residents and staff toured facility
06/04/2015	Contact - Face to Face Interviewed staff
07/06/2015	Inspection Completed-BCAL Sub. Compliance
07/10/2015	Comment- Email - Exit

The complainant reported the concerns indicated in this complaint came in, from someone via a letter to the court, on behalf of Youth 1; and so she forwarded a copy of it to BCAL in the form of the complaint.

#### **ALLEGATION:**

Staff have bumped into Youth 1 to antagonize her.

Staff is "Highly unprofessional", they gossip among each other, and kids. Personal information is shared with other residents by staff; and staff make fun of residents' situations, by talking about their mothers, saying that "they sell their pussy". And that staff make statements about the residents, such as that they are 15/16 years old and don't know how to "wash their asses", and tell residents to go tell their mama, "cause I'll whoop her ass too"..

#### **INVESTIGATION:**

Youth 1 reported Ms. Singleton, and Ms. Purifoy told other staff and residents hers' and other residents' person business, that they obtained from group sessions. She, indicated Ms. Singleton will say to you, "I'm not supposed to tell you this"; then she would tell you a resident's information Youth 1 indicated, Group D and Group E are female units; and that in their group classes, they must do life stories, whereby, they read information about themselves in the group; and if they don't do so they will lose points. She indicated, she didn't want to share/ to put her business out there, but she did; and then Ms. Singleton and Ms. Purifoy talked about her business, saying her "father is a crack head; and her mother's a bitch". She, indicated, she once wrote a request to see the doctor, because she was sexually active, and she was concerned about her body functioning; and so she gave the written request to Ms. Purifoy, who read it; and then told her "you're fifteen, sixteen, and you don't know how to wash her ass". Youth 1's reporting of why Ms. Purifoy said that was not clear; and Youth 1 did not apprise the supervisor of Ms. Purifoy actions.

Youth 1 also alleged that Ms. Singleton, and Ms. Harris had purposely bumped into her, so as to agitate her. Youth 1 was unable to give specific dates or places of the occurrences, but indicated Ms. Singleton, Ms. Harris, Ms. Purifoy, Ms. George, and Ms. Dawson were all unprofessional; that they gossip about the residents sometimes daily. Youth 1 also reported Ms. Singleton had laughed at her; and refused to allow her to call her therapist. She, indicated, this latter incident occurred one to two

weeks before she was transferred from DBI-Capstone main building to the Apex building April 21, 2015.

When asked, whether she informed the supervisor of Ms. Singleton's or Ms. Harris' actions, Youth 1, indicated, she told the female, morning shift supervisor, about it.

AM Shift Supervisor, Patricia Jones, employed with the facility since 2007, reported familiarity with Youth 1. She, indicated, Youth 1 was quiet, but very outspoken; and that Youth 1 stayed in her room most of the time she was at the facility. Ms. Jones, said, Youth 1, never complained about any staff bumping into, or expressed concerns that any staff was talking about her, her mother, or anyone else. Ms. Jones denied hearing or observing any staff talking to or treating Youth 1, inappropriately.

Therapist, Jessica Beane, reported, she was Youth 1's, therapist from the point Youth 1 was admitted in late February 2015 to her discharge to the Apex program, in April; and that Youth 1 never expressed concern that any staff was bumping into her. She said the residents have talked with her about staff throwing their personal business in their faces, but Youth 1, and the other kids, never named the staff, "because they know I will address it". Ms. Beane, said, many times, Youth 1 took a lot of what other kids said and ran with it. That it wasn't something that was done on or against Youth1; but Youth 1 tried to advocate it for the other kid, or she used it against that kid.

Ms. Singleton, Ms. Purifoy, Ms. Harris, Ms. George-Madison; and Ms. Dawson all denied the allegations against them.

Ms. Singleton, reported, she never bumped into Youth 1 playfully or on purpose; and that she never said anything inappropriate to Youth1; or talking derogatorily about her parents. She acknowledged there had been times that Youth 1 shared information in group, but she denied she ever used anything from group against Youth 1. She, reported, a good relationship and rapport with Youth 1; and reported Youth1 never showed any desire to not want to work with her. She, said, when Youth 1 was upset, she tried to calm her down; but most of the time Youth 1 didn't want to come out of her room; and lots of time, Youth 1 didn't want to attend group. Ms. Singleton denied observing or hearing any other staff say or act inappropriately to/with Youth 1, especially not "your mama" or "you don't know how to wash your ass."

Ms. Purifoy, indicated, she never had much interaction with Youth 1 or Youth 1's group, except in the morning, and during hygiene. She said, Youth 1 had particular staff she interacted with; and she didn't have a rapport with the youth because Youth 1 would tell her "you're not my staff, and wouldn't talk to me". Ms. Purifoy denied saying anything about Youth1's family, saying "your mama", or that Youth 1 was fifteen, sixteen and didn't "know how to wash your ass". She, also, denied hearing or witnessing any other staff doing so.

The other six residents interviewed related to this allegation, all, except two reported a concern with staff. The four residents reporting a concern were not specific with all details.

Youth 2 reported most of the staff treated her alright, but some can be rude. When asked for specifics, Youth 2, said once when she was cursing out Ms. Dawson, Ms. Dawson told her “your mama, your mama”. Youth 2 could not recall when that incident occurred, but said she informed, Ms. Brown (Program Coordinator). Youth 3 reported no problems with the staff; and she had not heard any staff talking or being inappropriate with residents. She, reported, familiarity with Ms. Yancey, Ms. Singleton, and Ms. Harris, but she reported not knowing Ms. Purifoy, Ms. Dawson and Ms. George-Madison (also known as Ms. George). Youth 4, reported never hearing any staff say anything negative or inappropriate to Youth 1, or any resident. She reported a good relationship with Ms. Yancey, Ms. Singleton, Ms. Purifoy, Ms. Harris, and Ms. Jones.

Youth 5 named Ms. Singleton, Ms. Purify, Ms. Harris, and Ms. Dawson as staff that she knew to have gossiped about residents or to have spoken with a youth inappropriately. She, said, she overheard Ms. Singleton gossiping about a peer; and calling Youth 2 a “hoe” because Youth 1 talks a lot. And that sometime in November, 2014, after she asked Ms. Singleton if she could go to her room, Ms. Singleton called her a “bitch”; because she (Ms. Singleton) didn’t want to do it. Youth 5, indicated Ms. Purifoy has a “smart mouth”; and gets into it with the residents; she could not give any specifics; but indicated Ms. Purifoy was moved from Group D to Group E for her (Ms. Purifoy’s) attitude. She, said, residents told Ms. Brown about Ms. Singleton, then Ms. Singleton tried to check the residents in group by saying stuff such as “I don’t need to talk about you, and your peers; and “I don’t need people going back and telling Ms. Brown I’m gossiping”. Youth 5 admitted she never heard Ms. Dawson say anything negative, “firsthand”, against residents, but indicated, other peers, told her, Ms. Dawson had said derogatory comments to them. Youth 5 also admitted, she had never heard Ms. Purifoy, or any other staff, tell a resident, “You don’t know how to wash your ass”. And she indicated Youth 1 “had a tendency to not tell the truth about things”.

Youth 6 reported she never heard Ms. Purifoy say anything inappropriate to any kid, that “She’s really positive”. She indicated, Ms. Harris “is really nice”; and that Ms. Dawson “can have her moments” , but she could not recall Ms. Dawson, or staff being inappropriate to any resident, inclusive of Youth 1. Youth 6 indicated, staff, (which ones she did not know), would talked about Youth 1, because Youth 1 was “troubled, and always trying to draw people into stuff”. Youth 6, also indicated, Ms. Singleton had stated that “some residents are rapists” and was telling their personal business; but Youth 6 admitted, she never personally heard Ms. Singleton say that; and she did not know when Ms. Singleton said such or what resident Ms. Singleton said it about. When asked, whether she had ever hear a staff tell, Youth 1 or any

resident “you don’t know how to wash your ass”, Youth 6 said, Youth 1 said that to her, that Youth 1, bullied her and was nasty to her.

When asked, whether she had ever heard any staff say inappropriate things to residents, Youth 7 indicated Ms. Singleton, “She does it a lot”. She indicated, Ms. Singleton was “really the only one” that says inappropriate things to residents. She said once “I confided in Ms. Singleton” about my sister” and her sister’s heroin use; and Ms. Singleton told the group she (Youth 7) used to help her sister use heroin. Youth 7 was unaware of any staff bumping into any resident on purpose

Shift Supervisor, Alicia Yancey indicated Youth 1, nor any other resident had come to her to complain about, Ms. Singleton, Ms. Dawson, Ms. Jones, Ms. Purifoy, Ms. Harris, or Ms. George- Madison being disrespectful or unprofessional to her/ them. She said, if the resident, had she would have followed up on it.

Ms. Chartun Harris; denied ever bumping into Youth 1 to irate or hurt her; and she denied hearing staff be unprofessional or inappropriate to Youth 1, or other residents.

Ms. Latonya George- Madison reported not having a relationship with Youth1. She said Youth1 was in Group E; she (Ms. George-Madison) works with Group D; and that the two groups do not come together. She denied talking about residents negatively, using their personal information negatively against them, or hearing other staff do so.

<b>APPLICABLE RULE</b>	
<b>R 400.4112</b>	<b>Staff qualifications.</b>
	A person with ongoing duties shall be of good moral character, emotionally stable, and of sufficient health, ability, experience, and education to perform the duties assigned.
<b>ANALYSIS:</b>	<p>The evidence is inconclusive, as to whether the identified staff persons acted unprofessional, or failed to show good moral character or ability, and experience in performing their duties.</p> <p><b>Consultation:</b> Notwithstanding the above, further exploration of Ms. Singleton, and Ms. Purifoy’s verbal relationships, and interactions with the residents, and portrayal of information related to residents should be explored further by the facility.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

Youth 1 has been attacked twice, and has not hit back, it is not clear if this was by a staff or another resident.

**INVESTIGATION:**

Youth 1 report she was attacked by her roommate, Resident 2, in her room when she first arrived at the facility. She, said, the door was closed and locked; another roommate, Resident 3, tried to stop it; and Ms. Bursee, who longer works at the facility due to being fired, just stood there. She, said staff did come in the room and restrained her, when she in term, started tearing up Resident 2's stuff. When asked about the restraint, Youth 1 said, it was a real restraint, and it was fine. Youth 1 denied being attacked by staff.

AM Shift Supervisor, Patricia Jones, employed with the facility since 2007, reported familiarity with Youth1. She, indicated, Youth 1 stayed in her room, most of the time she was at the facility. Ms. Jones was not aware of an incident whereby Youth 1 was attacked.

Therapist, Ms. Beane described Youth 1 as resistant, threatening, and sometimes aggressive; but indicated she was a follower. She, reported, being unaware of a time Youth 1 reported she was attacked by a resident.

Youth 2, denied an attack on or fight with Youth 1; but Youth 6, reported sharing a room with Youth 1, and getting into a mutual fight with Youth 1.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(2) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS:</b>	The evidence does not support the allegation, or a lack of supervision.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

Staff refused Youth 1's request to call her therapist during or after business hours; and two written grievance have not been addressed.

**INVESTIGATION:**

Youth 1 reported Ms. Singleton laughed at her, and refused to allow her to call her therapist. She, indicated, this incident occurred one to two weeks before she was transferred from DBI-Capstone's main building, to the Apex building, April 21, 2015. When asked, whether she eventually got to see a therapist, she indicated she did; and she named Ms. Savage as her current therapist. Youth 1, indicated, she had also written a couple of grievances, one in March and one in April; but they never got to the right person. When asked, whether she knew how to file a grievance, she, reported, knowing how.

AM Shift Supervisor, Ms. Jones, indicated, Youth 1 stayed in her room most of the time she was at the facility; and that she never knew Youth 1 to file a grievance. She, said, Youth 1 knew the process for filing a grievance, which is that the staff allows the resident to place the grievance in the grievance box. The grievance box is locked; and Ms. Henderson then retrieves the grievances from the box.

Therapist, Ms. Bean, reported, Youth 1 never indicated she made a grievance, or that that a grievance was not looked at. And, nor, that Youth 1 had asked to talk to her, and a staff wouldn't allow the request.

Ms. Singleton and Ms. George- Madison denied ever refusing to give Youth 1 a grievance form, or that they had heard any other staff refuse to do so. Each also denied they had refused to allow Youth 1 to call her therapist. Both indicated kids put their own grievance in the grievance box, and write their therapist request. Ms. George-Madison, indicated, if it's an emergency situation, she/they call the OCC.

<b>APPLICABLE RULE</b>	
<b>R 400.4132</b>	<b>Grievance procedures</b>
	An institution shall develop and follow written procedures for redressing concerns, complaints, and grievances of parents and residents.
<b>ANALYSIS:</b>	The evidence does not support the allegations, and reported by Youth1.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

Youth 1's mother has no means of transportation for visits, and the agency has not assisted with visitations.

**INVESTIGATION:**

Youth 1 reported Therapist, Jennifer Beane, told her DBI-Capstone would assist her mom with transportation, so that she and her mom could visit, but DBI never helped. She, said, she requested a visit, but one never happened, that Ms. Beane never set up a visit; and she (Ms. Beane) said she wasn't going to. That Ms. Beane told her she (Youth 1) had to get her sophomore stage before a visit occurred; because Ms. Beane, said, she wanted to make sure Youth 1" could act right, and still be on track".

When asked, whether a visit ever occurred for her, Youth 1, indicated she never had a visit while at the DBI main building, but one was pending for June 11, 2015 at the Apex facility. She, said, the facility was paying for her mom a bus ticket; and picking her mom up from the bus station.

Therapist, Jessica Beane, reported she was Youth 1, therapist from the point Youth 1 was admitted in late February 2015, until Youth 1's discharge to the Apex program

in April. She acknowledged the facility, and typically the CMO worker works together to assist residents' parents' with visitation. She, indicated, Youth 1 is from Ohio; and Youth 1's mother was hard to get in touch with. That Youth 1's mother never answered her calls; and Youth 1's mother didn't seem willing to participate in the process; and that the mother was a no show a number of time for telephone family sessions. Ms. Beane, said, Youth 1's mother, never said she didn't want to come for a visit; Youth 1's mother indicated she couldn't come, because she had other children. Ms. Beane, said, Youth 1 never asked her about her mother coming for a visit, though she also did not recall having a conversation with Youth 1 about her mother not visiting, due to the mother not wanting to. She, said, she had more contact with Youth 1's father, because he was more actively involved. She said, she was in the process of scheduling a visit for the father, and then Youth 1 switched programs. An April 2, 2015 phone contact, listed under a therapy summary for March 30, 2015 to April 5, 2015, indicated, Ms. Beane spoke with Youth 1's father, a visit was scheduled, and progress discussed).

Ms. Beane provided a copy of Youth 1's therapist session notes when showed varying attempts to contact Youth 1's mother and father; and a number of noted unsuccessful attempted contacts to Youth 1's mother. Ms. Beane denied the facility refused to schedule a visit for Youth 1's mother.

<b>APPLICABLE RULE</b>	
<b>R 400.4142</b>	<b>Resident and parent visitation.</b>
	An institution shall make provisions for visits between each resident and the resident's parents, except where parental rights have been terminated or the resident's record contains documentation that visitation is detrimental to the resident.
<b>ANALYSIS:</b>	The evidence does not support the allegation as reported by Youth 1.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **ALLEGATION:**

Youth 1 was prescribed medication without being informed what it was.

#### **INVESTIGATION:**

Youth 1, reported, the doctor didn't tell her he was prescribing her the medication, or what it was for. She, indicated, then the nurse tried to give her a medication, which she refused, a couple of times, because they wouldn't tell her what it was. She also said they did tell her she was being placed on medication, but they didn't call her mom; that usually for that kind of stuff, they typically called her dad; and he says yes to everything. She, said, she found out from speaking with the doctor, one week later, that the medication was Risperdal, and that they changed the dosage.

Therapist, Jessica Beane, reported Youth 1 was told about her Risperdal medication; and why she was taking it by the doctor. Ms. Beane, reported, she and

Ms. Tracey (Clinical Manager) also spoke with Youth 1 about the medication, and explained it, why it was needed.

<b>APPLICABLE RULE</b>	
<b>R 400.4160</b>	<b>Health services, policies and procedures. Dispensing medication.</b>
	An institution shall establish and follow written health service policies and procedures addressing all of the following: (e) Dispensing medication.
<b>ANALYSIS:</b>	The evidence does not support the allegation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

The residents always run out of hygiene products, and were out for three days.

**INVESTIGATION:**

Youth 1, six other residents, and eight staff, and the Director, Kathleen Boyes were interviewed about this complaint.

Youth 1 reported, they ran out of hygiene products, like soap, toothpaste, and deodorant fast; and she had to wait until the next supply date. When this Consultant asked Youth 1 to explain, and whether all residents went without these items; Youth 1 indicated she went without soap for four days. She, said, she believed the facility had the item, but she did not get it. She, said, she would ask for soap, and not get it; then some other kids would ask for soap, and they got soap. She, said, it was Ms. George (also known as George-Madison), who would not give her soap. When this Consultant asked Youth 1 whether she asked Ms. George why she wouldn't give her soap, Youth 1, said, she did; and Ms. George told her she (Ms. George) wasn't her staff, meaning Youth 1 needed to ask the staff person handling Youth 1's group.

AM Shift Supervisor, Ms. Jones, reported the facility never runs out of hygiene products. She, said, staff, Ms. Beamer was good about ordering these products, and keeping them stacked. She, said, each resident has his or her own hygiene box.

Therapist, Ms. Beane reported residents, in general, have complained about no soap or hygiene products; and that she had even held a group with the girls about this. And that each time, when she, and, the Director, Ms. Boyes, checked the residents' boxes, the residents always had what they needed in them.

Youth 2, Youth 3, Youth 5, and Youth 7 reported they are provided with hygiene products; and they never run out. Youth 4 reported hygiene products are provided, but they ran out once, "like for a couple of days", but she was not sure why they ran out. Neither resident reported a problem getting soap, or knowing of all kids getting



soap, but one kid. Youth 5, and Youth 6 were, inadvertently, not asked questions about hygiene products.

Ms. Shamitra Singleton, Ms. Rozena Purifoy, Ms. Chartun Harris, Ms. Latonya George-Madison, and Ms. Roxanne Dawson, as well as Supervisor, Alicia Yancey reported the facility did not have a problem with hygiene products. Ms. Singleton, indicated, they may from time to time run out of combs, but never soap, deodorant, or sanitary items. She also indicated that at times items may be locked; and they may have to wait for another staff to bring the key. Ms. George- Madison denied refusing to give Youth 1 soap, when asked.

Ms. Boyes reported the residents have plenty of hygiene products.

It is noteworthy the girls' hygiene boxes were checked, during this Consultant's special inspection, and appropriate hygiene items were observed.

<b>APPLICABLE RULE</b>	
<b>R 400.4168</b>	<b>Personal hygiene.</b>
	An institution shall assure that each resident maintains or receives personal care, hygiene, and grooming appropriate to the resident's age, sex, race, cultural background, and health needs.
<b>ANALYSIS:</b>	Personal hygiene products are available; and are provided the residents for their care and grooming. The evidence does not support the allegations as reported by Youth 1.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

The facility electricity was out on 3/29/2015; and residents missed one meal. The residents are fed apples, and bread with mold on them.

**INVESTIGATION:**

Youth 1, six other residents, eight staff; and the Director, Kathleen Boyes were interviewed about this complaint.

Youth 1 reported that sometime in March 2015, the facility lights went out for a long time. That the incident occurred sometime after breakfast, lasted the whole day, and the facility didn't know how to turn them back on. Youth 1, said, the lights came back on late that night, and while they were out, it was hard for them to see how to do things, no visits, and staff had to pop the doors to get them out.

Youth 1 denied missing a meal the day the lights were out; but reported one week later, she didn't get breakfast or lunch. She said, staff said they came with her meals, but she was asleep, and they couldn't wake her. She said, she had left from class to go to her room, due to a headache, and vomiting in associate with her

period; and that she didn't believe staff tried to wake her. She said, she and another resident across the hall from her didn't get their breakfast or lunch; and no one left it on a tray for them; and they banged on their respective doors about it later. When asked, whether she complained to some about this, Youth 1 said, she told Ms. Yancey and Ms. Roberson, and they said they came, and woke her up, but she does believe they did, because two days prior to that incident, when she was asleep, they put her food on the partition in her room. She, said, she asked them, why they didn't leave her meal on the partition; and they just said they tried to wake her.

Youth 1 reported lots of the food had mold on it; and that once, in March, a couple of day after she didn't get her meals, she had an apple with mold on it. She, said, she took the mold off, and bit the apple, but it had little fuzzy stuff inside, and she dug out the stuff with a spoon. When asked, whether she told staff about the molded apple, she said, she told Ms. V, and Ms. V refused to get her another. She stated, "staff tell you to let them know if something is wrong, that they will get you another, but they don't".

Each staff, and resident interviewed acknowledged that the facility's lights went out once in March 2015. AM Shift Supervisor, Patricia Jones, reported the light were out for a couple of hours; and it had something to do with a generator. She, indicated, the facility was equipped for the situation; they used candles, flashlights; and no one missed a meal. She, said, the lights went out around lunch; and that outside food was brought in for the residents. She indicated, that "the food, in general, is pretty good, I eat it". And, she could not recall a time any resident said they found a mold on bread or an apple. She, said, if such had occurred, the resident would be given a new plate; and the Food Service contractor would be contacted.

Therapist, Jessica Bean was not aware of any problems with the food. She recalled some residents informing her there was a time there was a power outage, but she was not there; and the kids said it wasn't for twenty-four hours; and that food got catered in. Ms. Beane reported not being aware of a time Youth 1 missed a meal, because Youth 1 was on a "sick call". She, indicated, staff always provides the kids meals; and she knew at times Youth 1 would give her snacks away, and then complain about it afterwards.

With the exception of Youth 3, who had only been at the facility for about two months; and who did not recall the facility ever losing power, Youth 2, Youth 4, Youth 5, Youth 6, and Youth 7 all recalled the lights/ power going out for part of the day; and staff still providing care to them. None of these residents reported missing a meal; and all reported food was brought in, and it was good.

Five of the six other residents interviewed, reported they never received food that was spoiled, or molded; or that they ever observed another resident to receive such. The sixth resident, Youth 2, also had not known any kid to get molded food; but, she stated, one might get spoiled milk or juice. Youth 2 also indicated, if that was to happen," you let staff know, and staff takes it from you, and give you something

else". Additionally, Youth 3 reported the only problem she had about the food was that sometime it may not be what she wanted; like she "might want pizza; and they are serving something else". Youth 6 reported seeing a hair in the food once, but indicated it was reported; and a new plate was given.

Director, Kathleen Boyes, acknowledged there had been a power outage in the area on March 29, 2015, that affected this facility; and their main office. She affirmed what others indicated, about the lights being out for several hours, and that no meal was missed. She, indicated, water, and dinner was purchased, and brought in for the residents and staff. She provided a copy of a receipt showing the purchase of the meals for that day.

Shift Supervisor, Alicia Yancey denied there being a time Youth 1 did not get breakfast or lunch due to her sleeping. She, said, that never happened. She, said, Youth 1 was always in her room; but there was never a time, Youth 1 was not fed due to sleeping.

<b>APPLICABLE RULE</b>	
<b>R 400.4169</b>	<b>Resident nutrition.</b>
	(1)A licensee shall provide a minimum of 3 nutritious meals daily unless medically contraindicated and documented.
<b>ANALYSIS:</b>	Youth 1 and other residents were not deprived of a meal. The evidence does not support the allegations, as reported by Youth 1.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4169</b>	<b>Resident nutrition.</b>
	(2) Meals shall meet the nutritional allowances recommended in the publications entitled "basic Nutrition Facts," pages 28 29, Michigan Department of Public Health publication no. H 808, 1980. This publication may be obtained without charge from Nutrition Services, Bureau of Personal Health Services, Michigan Department of Public Health, P. O. 30035 , Lansing Michigan 48909.
<b>ANALYSIS:</b>	There is insufficient evidence to support the allegations that Youth 1 or other residents were fed spoiled or molded food, or deprived of a nutritious meal.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4170</b>	<b>Emergency and disaster procedures.</b>
	Rule 170. An institution shall establish and follow written procedures for potential emergencies and disasters, including fire, severe weather, medical emergencies, and missing persons.
<b>ANALYSIS:</b>	The agency adhered to procedure, and no services were sacrificed due to a temporary loss of power.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

Residents have not been able to do physical activities, because they do not have shoes for gym.

**INVESTIGATION:**

Youth 1, six other residents, and eight staff were interviewed about this complaint.

Youth 1, reported, she, and other female residents were unable to do activities because, they did not have good gym shoes. She, said, the gym shoes they had were bad, worn, and the wrong sizes, either too big or too small. When asked, if not having gym shoes prevented her from doing recreational activities, Youth 1 said, "yes". She, indicated, that after a resident had hurt her ankle in the flip flops they wear, staff stop allowing them to play in their flops. She, said, the facility staff said they ordered gym shoes, but they hadn't come a month after she wrote a letter; nor had they come before she left the facility. Youth 1, said they ordered chairs; and they came, so she couldn't understand why the gym shoes wouldn't have come, if they had been ordered.

AM Shift Supervisor, Ms. Jones, indicated, Youth 1 stayed in her room most of the time she was at the facility. She, said, there was no time that kids were not provided activities, and couldn't participate in gym because of no shoes. She, said, Youth 1 has very small feet (size 5) so, there may not have always been a size for her, but she never missed gym because of shoes; that if she did, it was because she didn't want to, or she wouldn't leave her room.

Therapist, Ms. Beane, indicated Youth 1 never complained about not being able to participate in gym for lack of gym shoes. She, said, Youth 1 didn't participate in much of anything, while at the facility, that Youth 1 took "sick call" to go to her room a lot.

Youth 2, and Youth 7 were inadvertently not asked about this allegation, Youth 3, reported, there was never a problem with gym shoes; or residents not being able to participate in gym. Youth 4, reported there were no new shoes, for the girls, but the boys have always had shoes. She, said, a shoe order was to have taken place for the girls, but she didn't know if it had been done. She, indicated, kids were still participating in gym. Youth 5, reported the girls have gym shoes, but they are holey

and smelly. She, said, the boys have gyms shoes, but she didn't think, the girls' Group D does. Youth 6, also reported the shoes for the girls are "old and broken down". She, said, the facility ordered gym shoes, but there wasn't enough for the girls. None of the four residents, interviewed about this complaint, reported an inability to participate in activities because of a lack of shoes.

Supervisor, Ms. Yancey, reported Youth 1 had gym shoes; and she used to keep them in the gym closet on the shelf. Ms. Yancey admitted the gym shoes are old; and some do stink, but said they never forced the kids to wear them. She, also indicated Youth 1's lack of participation, in gym, was not due to a lack of gym shoes, but was due to Youth 1 not wanting to participate.

Ms. Singleton, reported, Youth 1 didn't participate in gym because she did not want too, not due to no gym shoes. Ms. Purifoy, could not recall how often Youth 1 participated in gym, but reported there was a point in time that the girls' gym shoes were pretty bad off, and a few kids didn't want to use them; but no staff was pressing the kids to use them. She, said, it took a few days to get new shows, but kids could do other things to participate in gym.

Ms. Harris, reported there was a period of time, the kids couldn't play in the gym shoes, because they were old, torn, and holey; but kid participated in other activities, like dance, and using the punching bag. She, said, some kids tried to play in their Crocs, but they discouraged that for safety reason. She, said, the girls' old shoes were throw out two months ago, new ones were ordered, but the company sent boys' shoes sizes; and they had to be sent back. Ms. George -Madison reported basically what Ms. Harris reported. She, also reported, everyone has gym shoes now; and that prior to receiving the new shoes; no kid missed out on physical or recreational activities. Ms. Dawson basically reiterated what the prior two staff indicated; and reported the girls' gym shoes came in yesterday (The day prior to Ms. Dawson's interview with this Consultant).

**Reviewed:**

- Observed a box of new gyms shoes for the Group D and Group E on the girls' unit.

<b>APPLICABLE RULE</b>	
<b>R 400.4176</b>	<b>Recreational activities, equipment, and supplies; swimming restriction.</b>
	(2) Appropriate recreation supplies and equipment shall be provided.
<b>ANALYSIS:</b>	The evidence does not support the allegation as reported by Youth 1.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

Huge roaches are in the facility and come out of the vents. The showers flood and are not clean.

**INVESTIGATION:**

Youth 1, six other residents, eight staff, and the Director, Kathleen Boyes were interviewed about this complaint.

Youth 1 reported there are big flying roaches at the facility, and that dead and live roaches are in various spots in the building, even the trash, but mostly the down stairs bathroom. She, indicated, roaches can be seen daily, usually one or two at a time. She, said, staff had said they are on the girls unit, but she had never seen them down there. She also reported she had not seen them in the kitchen, but that, about a week after she had arrived at the facility, a roach flew into her food. She, said, "The roach sat there then left"; and staff wouldn't give her another plate. That staff said they had too many kids to feed. Youth 1, said, she didn't want to eat the food, so staff Ms. Singleton brought her food from the outside.

When asked, whether, the facility sprayed regularly for bugs, Youth 1, stated "they didn't spray while I was there".

When asked, whether there was ever anything wrong with the showers, Youth 1, reported, there were problems with the two showers on the girls' unit; that they would always flood; and they had a molded smell to them. She reported, the pole that held the shower curtain was also broken, and they had to shower without the curtain, therein, allowing other residents to see them shower.

She also indicated being cold in the facility, and staff not giving her an extra blanket when asked, or giving her an extra pair of long john pants.

Am Shift Supervisor, Ms. Jones reported, she had never seen any roaches; and that she knew they come out to spray for pest about once a month. She was not aware of a problem with the showers.

Therapist, Ms. Beane reported being unable to count the number of roaches, she has seen since her employment in November, 2014; which she thought was normal for a facility like this. She recalled the facility spraying, for pest, three times, since she started working at the facility.

Shift Supervisor, Ms. Yancey reported each youth is provided clothing to wear; and bedding that includes thermal-pants, and blankets. She, said, any kid asking for an extra blanket, and or thermal-pants, are provided such; and no resident is refused.

Youth Specialists, Shamitra Singleton, Rozena Purifoy, Chartun Harris, Latonya George-Madison, and Roxanne Dawson, as well as Supervisor, Alicia Yancey basically concurred that the facility does not have a roach problem or infestation.

Ms. Singleton admitted seeing a couple of dead bugs in the kitchen , but never near the food; and Ms. Harris, and Ms. George-Madison each indicated they had seen a few bugs; but they thought or perceived them as water bugs. Some of these staff had not seen when the facility had sprayed, but all were aware that the facility's maintenance department handled the care of issues in this area.

As for any problems with the girls' showers, Ms. Harris was inadvertently not asked about the showers. However, Ms. Singleton, Ms. Purifoy, Ms. Harris, Ms. George-Madison, and Ms. Dawson were interviewed about this. Ms. Singleton, and Ms. Purifoy, indicated the showers are clean; and that every now, and then, they flood; and that the shower rods may fall. Ms. Purifoy, indicated, the showers are better than most; and that one shower was out once, for two to three days. Both she, and Ms. Singleton, indicated, the showers' upkeep is that of maintenance', and when problems are reported, it's taken care of quickly. Ms. George-Madison reported there was no problem with the showers, no mold, and no problem with the shower rod. She, said, when the shower does floods, maintenance repairs it right away. Ms. Dawson, reported, the shower rods are plastic; and whenever there is a problem with them, maintenance is called. She, said, there is no problem with the shower curtain, and no one has showered without a shower curtain.

Youth 2, Youth 4, Youth 5, Youth 6, and Youth 7 all had seen as many a few to a lot of live, and or dead bugs, or roaches, of which some residents reported were big; and at time seen in the hallways, basement, and kitchen. Youth 3 reported she had never seen any roaches; and that she does not pay attention to stuff like that. None of the residents were aware of when the facility sprayed for bugs.

Each of the six youths reported above, were also interviewed about the shower complaint. Youth 2 reported no problems with the girls' showers, shower rods or the curtains. Youth 3, and Youth 4, indicated, the showers are clean. Youth 3 never knew of a problem with the showers or the rods; and Youth 4, indicated, no flooding of the showers, but indicated the shower rod had broken, and it was fixed right away. Youth 5 reported the showers use to flood a lot, and that they stunk of mildew; and are not often cleaned. She said, the curtain rod had broken a few times; and for about a week to a month, the curtain would always fall because of the rod. Youth 6, reported there is mold in the showers, and "they are nasty and stinky". Youth 6, also indicated sometimes the shower rod is missing or broken. She said, the shower rods are plastic, and tape is used to hold them up. Youth 7, reported, the showers are "really, really dirty, the tile needs cleaning, no one clean them". She, said, in their showers, "you can't have a real curtain rod, so they have to use plastic ones, which don't fit, and they have them duct taped'.

Director, Boyes and the maintenance manager, reported the facility sprays for pest control regularly. An agency binder was shown to this Consultant, which showed monthly inspection and treatment dates by the "Pest Pounders" agency going back, months, inclusive of last year. The last inspection and treatment date recorded at that time, was May 20, 2015.

**Reviewed:**

- Pest control inspection and treatment binder.
- Toured the facility during the special investigation inspection; and no bugs or roaches were seen, at that time.
- Viewed the two showers indicated for the female residents, at which time, the area appeared clean; and no flooding of the showers, was seen when the showers were turned on, and the water was allowed to ran for a while.

<b>APPLICABLE RULE.</b>	
<b>R 400.4407</b>	<b>Facility and premises maintenance.</b>
	(1) A facility and premises shall be maintained in a clean, comfortable, and safe condition. The facility shall be located on land that is properly drained.
<b>ANALYSIS:</b>	Flooding of the showers was not concluded from the evidence; and the area appeared clean
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4407</b>	<b>Facility and premises maintenance.</b>
	(3) The facility, including main and accessory structures, shall be maintained so as to prevent and eliminate rodent and insect harborage.
<b>ANALYSIS:</b>	In an effort to prevent and eliminate rodents and insects, the facility sprays monthly.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

During the course of the investigation, some residents reported mold and or mildew in the showers; and that the curtain rod or rods falls or were broken; and that duct tape was use to hold up the shower rod or rods.

**INVESTIGATION:**

Toured the facility during the special investigation inspection; and viewed the two showers indicated for the female residents. Heavy mildew was observed on one shower curtain, and light mildew on the other. The shower curtain for one shower appeared to be too large, and was doubled over to serve as one. Additionally, the shower curtain rod in both showers, which were in deed plastic, as indicated by some interviewees (Understandably so, due to safety issues), were not secure. They were being held in place by black duct tape; which could be a safety issue to some residents.



<b>APPLICABLE RULE.</b>	
<b>R 400.4407</b>	<b>Facility and premises maintenance.</b>
	(1) A facility and premises shall be maintained in a clean, comfortable, and safe condition. The facility shall be located on land that is properly drained.
<b>ANALYSIS:</b>	Flooding of the showers was not concluded from the evidence; but the evidence showed, at least one shower curtain was too large; the shower curtains were mildewed, in need of replacement; and the shower rods were secured with black duct tape, which could pose a risk of harm to some residents.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, continuation of the facility's current licensing status is recommended.

**July 28, 2015**

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:

Linda Tansil  
Area Manager

Date July 30, 2015



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING

NICK LYON  
DIRECTOR

August 3, 2015

Kathleen Boyes  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2015C0420040  
Detroit Capstone

Dear Dr. Boyes:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

A handwritten signature in cursive script that reads "Lonia Perry".

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2015C0420040
<b>Complaint Receipt Date:</b>	06/05/2015
<b>Investigation Initiation Date:</b>	06/05/2015
<b>Report Due Date:</b>	08/04/2015
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2014
<b>Expiration Date:</b>	09/29/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
Resident A alleged that after he threw cards in a staff's face, and spat on staff, he was restrained; and while being restrained, staff kicked, and punched him. He also alleged he was choked, and he blacked out from the incident, and wasn't allowed to attend court the next day.	No
It was also alleged Resident A was called faggot and gay by staff.	No
Staff often withholds soap and deodorant from Resident A, because they are not fans of his.	No
Additional Findings	No

## III. METHODOLOGY

06/05/2015	Special Investigation Intake 2015C0420040
06/05/2015	Special Investigation Initiated - Letter Email to Director RE complaint
06/05/2015	Contact - Face to Face Interviewed, Resident A, staff, Gary Solomon, Denolius Burkes, Devon Washington, spoke with Director, K. Boyes, rec'd incident report, nurse note
06/12/2015	Contact - Face to Face Interviewed Resident B, reviewed video
06/19/2015	Contact - Document Sent Email to and from DHS Worker
06/19/2015	Contact - Document Sent Email to and from Director
06/25/2015	Contact - Face to Face Interviewed Youth Specialist, Jason Carter, Antonio Dumas, Supervisor Alicia Yancey, spoke with Director K. Boyes
07/01/2015	Contact - Document Sent Email from and to DHS Worker
07/02/2015	Special Investigation Full Compliance

**ALLEGATION:**

Resident A alleged that after he threw cards in a staff's face, and spat on staff, he was restrained; and while being restrained, staff kicked, and punched him. He also alleged he was choked, and he blacked out from the incident, and wasn't allowed to attend court the next day.

It was also alleged Resident A was called faggot and gay by staff. Staff often withholds soap and deodorant from Resident A, because they are not fans of his.

**INVESTIGATION:**

All staff, and residents interviewed were interviewed by this Consultant, and the DHHS Worker.

Resident A reported he "got into it" with staff Mr. Burke. He, indicated, he went into the kitchen to see what was going on, why the staff was screaming for help. Resident A said Mr. Burke had another resident by the collar; and while Resident A, was in the area, Ms. Burke was pushing that resident on him. He asked Mr. Burke why he was pushing the resident on him, and Mr. Burke told him he looked like he "wanted to turn it up, to get crazy", and get restrained. Resident A said he just walked away. He said, he had cards in his hand, and Mr. Burke said, look like you want to throw those cards, and Resident A, said, "Yes, I want to throw them in your face", but he didn't. He, said, he sat back down, but then more staff, Ms. Yancey, Mr. Dumas, Mr. Carter and other staff came. That the staff said they were trying to see what was going; and Mr. Burke told them he(Resident A) threatened to throw cards at him; and Ms. Yancey said, "Hoe, you're going upstairs all day, you're going on a sick call". Resident A, said, he didn't want to go; and Mr. Carter, Mr. Dumas, and two other staff grabbed him. That they were pushing him out the room; so he threw the cards up in the air, then four of five staff restrained him; and slammed him into the wall. He said, his arms were behind his back, and he was being punched; and "they were doing extra stuff with their elbows, and arms; and he looked back and it was Mr. Dumas". That Ms. Dumas was punching him, elbowing him, and the hits were landings on the right side of his face. Resident A, said, he told the staff several times, he meant no harm, but they threw him to the ground, and were kicking him. Then, he said it was Mr. Dumas who was kicking him; and he asked why he was being kicked; and Mr. Dumas said "because you threw cards at a female staff". Resident A, said he spat on Mr. Dumas, then the staff put him on his stomach; and Mr. Dumas choked him, and said "you gonna spit on me". He, said, the staff was all over him; and he told them he was being choked; and Ms. Yancey, said "Little boy nobody's choking you". Then Ms. Yancey, said "let's put him in the elevator where nobody can see him" because no cameras are there. And Mr. Dumas agreed with that; and he (Resident A) pleaded with them not to put him on the elevator.

Resident A said Ms. Yancey allowed Mr. Dumas, and the other three or four staff to grab him, and put him in the elevator. That Mr. Dumas held him by the collar, threatening him, saying "so you want to spit on a grown man, spit on me now, spit on me now". Then they took him to his room. When asked what was Mr. Carter and the

other two staff doing, Resident A, said they were just standing there looking, doing nothing. He said all the staff that were on the elevator took him to his room; and once in his room, he asked Ms. Yancey why would she allow this to happen to him, and Ms. Yancey said, "little boy no did anything to you". He, said, they were all laughing at him, and then they left. He, said, he went to sleep, then two hours later, he saw blood on his pillow; and when he looked in the mirror, he had scratches on both sides of his neck. (Scratches were seen on Resident A's face, one slightly red with blood; and two slightly healed scratches).

When asked, whether he saw the nurse after the incident, Resident A, said, the nurse came, but he told her he didn't need to see her, that he had no bruises. Resident A reported, he refused to see the nurse, because he wanted the court to see his bruises, but then he didn't go to court. When asked, whether there was another incident, other than the one he described Resident A said, no. He indicated this incident happened one June 1, 2015, between five and six o'clock PM. When asked, whether he reported the incident to anyone, he indicated he told someone on the midnight staff, an "OG", whose name he did not know. He indicated all the staff have each other's back, and he should have known that.

Resident A did not report being called faggot, by staff, and this Consultant and the DHHS Worker, inadvertently did not asked a question as to whether he had. Resident A only reported hearing staff, (no particular staff person was named), call another resident "a little B"; and that the resident had shown everyone how weak he was. Resident A did not report a problem getting soap or deodorant from staff; and the DHHS, and this Consultant inadvertently forgot to ask him a direct question about this allegation.

Director, Kathleen Boyes, reported the incident occurred in the morning, not in the evening. She, indicated, Resident A, has a mental illness, and he might report an incident happened at night, when it was day time. She, reported Resident A was not restricted from going to court, that per his therapist, Resident A's Worker requested he not be brought court, because the Worker thought Resident A might act out violently. Ms. Boyes, indicated, afterward, she spoke with Resident A's Worker; and the Worker affirmed she didn't think it was a good idea for Resident A to be at court.

Ms. Boyes reported soap and deodorant is given to all residents in the resident's hygiene box. She, said, these are not items left in the resident's room, due to possible self-harm, but all resident are provided them, when needed. Ms. Boyes was not aware of any residents, or staff taunting Resident A, calling him gay or using racial slurs toward him.

Youth, Specialists, Gary Solomon, Denolius Burkes, Davon Washington, Jason Carter, Antonio Dumas, Resident B, and Supervisor, Alicia Yancey each reported familiarity with the incident.

Mr. Solomon, reported, Resident A went toward Mr. Burke aggressively, threw cards toward Ms. Yancey's face, and Resident A was taken to the wall. He, said, they had Resident A's arms out; then Resident A started "to buck" and they (He, Mr. Carter, Mr. Dumas) restrained him with his arms to his back. He, indicated, as they were bringing Resident A down to put him in the settle position, it was hard, to do it smoothly, because Resident A was aggressive, cursing, "bucking, and spitting". He, indicated, when Resident A went to the floor, Resident A was sitting on his butt with his leg out; and he(Mr. Solomon) got on Resident A's legs to stop Resident A from kicking. He said, prior to that Ms. Yancey had been on the resident's legs. He, said, it took a good while for Resident A to calm down, but he did, and they escorted him to his room.

When asked, whether anything happened on the elevator, in route to Resident A room, Mr. Solomon, reported, Resident A was doing a lot of cursing. He said, Resident A was still in the restraint, while on the elevator, and Resident A's face was facing the back of the elevator. He, Mr. Dumas, Mr. Washington, Ms. Yancey, and Mr. Carter were on the elevator, and Resident A was not aggressive on the elevator. He, indicated, as they walked Resident A to his room, Resident A stopped, motioned as if he want to resist, but he didn't. Mr. Solomon, said, no one kicked, or punched Resident A while they were on the elevator; and from what he witnessed downstairs, in the lunch room no one did so then.

Mr. Burke, reported, Resident A to be in Group B; and that that group, Group A, and Group C had been fussing. And before the incident, Resident A was determined to have a fight with Group C; and he had warned Resident A and another resident, no fighting. That once he got the group in the cafeteria, Resident A stood up, and threatened another resident in Group C, and Resident A was told to sit down; and the call was made for Group A to transport, but Resident A and two other residents tried to run out the back of the door. Mr. Burke got the other two boys; and told Resident A to come, back, and when he came back Resident A was on the cabinet. When Mr. Burke instructed Resident A to get down off the cabinet, Resident A threatened to throw cards at him; and assistance was called for; and Ms. Yancey, Mr. Carter, Mr. Dumas, and Mr. Solomon arrived. Resident A then threw cards at Ms. Yancey; and Resident A was escorted out of the lunch room by Mr. Dumas and Mr. Carter. Mr. Burke, reported, as they got Resident A to the hall, Resident A began to spit, and buck, so they put Resident A up against the wall in the hall, and Resident A's face was turned to the side. He, said, Resident A continued to spit, and make threats; so he, and the other staff grabbed Resident A's arms, and they pulled Resident A into the seated position. Mr. Burke said he had one shoulder, and other staff, which ones, he could not remember had Resident A's arm. He, said, when they got Resident A to the floor, Resident A spat on, and head butted Mr. Dumas, and tried to spit on and head butt a number of other staff.

When, asked, whether Mr. Dumas, or any of the staff choked, kicked or hit Resident A, Mr. Burke, stated "nothing like that ever happened"; no one, hit punched, kicked, or had their hands on Resident A's neck. Mr. Burke, said, he escorted Resident A

to the elevator, but he did not get on, the other staff did. When asked, whether he pushed or wrestled a resident into Resident A, Mr. Burke, indicated, Resident A made that claim, but Mr. Burke denied doing such.

Mr. Washington reported he ran to the cafeteria, after there was a call for assistance. He, reported, from what he knew, someone had asked Resident A to do something; Resident A threw playing cards at Ms. Yancey, and Resident A got restrained. He, said staff, tried to escort Resident A to the hall, by putting a hand on his shoulder; and they got him to the hall, then Resident A got aggressive. At that point, Mr. Washington blindside-swooped Resident A, and took both of the resident arms; and they got Resident A seated on his behind. Mr. Washington, indicated, he was sort of on his knee in the restraint; and Ms. Yancey was on Resident A's legs. He, indicated Ms. Yancey switched out; and Mr. Carter and Mr. Dumas were holding Resident A's legs; and Resident A was kicking and spitting. When asked, whether anyone punched, kicked, or choked Resident A, Mr. Washington reported no staff kicked, punched or choked Resident A. He, indicated, he would was seen that, because, he was looking at Resident A's head and neck area. He, said, Resident A was saying they were "Bitches, and no ass staff" and that he was going to get everyone fired. When asked, whether, Resident A at any point said, he wasn't resisting; and he meant no harm, Mr. Washington, said, no.

Mr. Washington, stated, it took them fifteen to twenty minutes to get Resident A calm, after which time, they got him up, and took him to the elevator. He, indicated he, Mr. Dumas, Mr. Carter, Mr. Yancey and Mr. Solomon were on the elevator. He reported, when they took Resident A to the elevator, he still had Resident A in the restraint; and Resident A's face was facing the back of the elevator. He, said, no staff kicked or hit Resident A on the elevator; that no one else had hands on Resident A. He, said, Resident A was calm and apologetic; and no longer resisting. He said, there was a brief moment, as the got in the hall to take him to his room that Resident A tried to resist, that Resident A broke one of his arm's free from the restraint; but Mr. Carter helped him( Mr. Washington) get his "hook back in place". When asked, what if anything was Mr. Solomon involved in, Mr. Washington, indicated, Mr. Solomon was talking to Resident A when they were in the hallway near the lunch room; and Mr. Solomon was one of the main reasons Resident A got up.

Resident B reported Resident A was walking forward as Mr. .Burke tried to get another resident contained; and Resident A walked into or bumped that other resident. Then Resident A got mad, and threw cards into the air. He, indicated, Resident A wasn't trying to hit Ms. Yancey, but the cards hit her in the face; and staff, Mr. Dumas, Mr. Carter, Mr. Burke, and Mr. Harper( he was not sure about this one) took Resident A to the ground. Resident B, said Mr. Carter initiated the restraint, by putting Resident A's hand behind his back, and took Resident A to the ground in the hallway. Resident B, stated, he was standing there watching, so he saw it himself. He, said Resident A was resisting the whole time staff was trying to calm him; and it took about ten minutes. Resident B said, Resident A was asking



staff “why you restraining me, I didn’t do nothing”. He said, Resident A was not cursing; but Resident A said he was going to write a grievance. When asked whether, he saw anyone hitting, kicking Resident A, or with their hands around Resident A’s neck; Resident B did not.

Mr. Carter also reported responding to a call for assistance; and when he, Mr. Dumas and Ms. Yancey got to the lunch room; Mr. Burke said Resident A was going to throw cards in his face. He, asked Resident A to walk with him, and Resident A got mad, called Ms. Yancey out of her name; and as Resident A walked out, Resident A threw cards in Ms. Yancey’s face. Then he(Mr. Carter), initiated the blindside-swoop, but couldn’t get Resident A’s other arm, because Resident A was resisting, by fighting, wiggling. He said, Mr. Dumas, took Resident A’s right arm; and then they placed Resident A against the wall with Resident A’s chest on the wall. He, said, due to Resident A being a bigger kid, he (Mr. Carter) “couldn’t get his hooks in good” and Mr. Washington came, and put Resident A into the proper PRT; and he(Mr. Carter), and Mr. Dumas basically did the escort. Mr. Carter, said, Resident A was still fighting and resisting the restraint, so Mr. Washington sat Resident A down in the settle position, and he, and Mr. Weisman, held Resident A’s legs. Then Mr. Washington got Resident A up, and they escorted him to his room by way of the elevator; and Resident A was not resisting all the way.

Mr. Carter, reported, after Mr. Washington turned Resident A around, Mr. Washington had Resident A facing the door of the elevator; and no one else was physically managing Resident A in the elevator. He, indicated, he, Ms. Yancey, Mr. Dumas, and Mr. Washington were the staff on the elevator; and no one kicked, punched or choked Resident A on the elevator, nor anytime he was on the scene of the incident. He, said, Ms. Yancey didn’t say let’s get him to the elevator to do something to him, she said “let’s take him to the elevator to get him out of the hallway”. Mr. Carter denied there was ever a time that Resident A was unconscious or that Resident A blacked out.

When asked, whether he saw any marks of bruises on Resident A, after the incident, he did not. When asked, whether any resident had made racial or derogatory slurs at Resident A, Mr. Carter was not aware of such. Nor was he aware whether Resident A had or had not attended Resident A’s court hearing.

Ms. Yancey, reported, she asked Resident A to come with her to the hall; and he acted as if he was, then he threw cards at her. She, said, as Mr. Dumas and Mr. Carter were escorting Resident A out of the cafeteria, Resident A got out of control; he was kicking and spitting. Mr. Washington restrained Resident A, put him into a blindside-swoop, to place him into the settle position, but that wasn’t working. She, said, Mr. Washington was still trying to hold Resident A; Resident A was kicking, so she got on his legs. Ms. Yancey, said, Resident A was still kicking and spitting, cursing, and trying to head butt, so the staff said they needed to get her out of there, so Mr. Wiseman got on Resident A’s legs. She said, Resident A still wasn’t calming down, that several staff tried to calm him.

Ms. Yancey denied saying let's get Resident A into the elevator, away from the camera, to do something to him. She, said, she said let's get him out of the hallway, so that they could get him to the elevator, and upstairs to his room. She, said, when they got to the elevator, Mr. Washington backed Resident A onto the elevator, and no other staff had hands on him; and Resident A was calmer. She, said, Mr. Dumas was on the elevator, but Mr. Dumas didn't touch or have hands on Resident A. She, said Mr. Washington took Resident A off the elevator, and a short ways down to his room, Resident A tried to break away; and Mr. Carter and Mr. Solomon assisted in holding Resident A to get him to his room. Ms. Yancey denied that any staff kicked or choked Resident A downstairs in the hallway or on the elevator; or that Resident A ever told her staff did so. She, also denied calling Resident A little boy, or saying something negative to him on the elevator. She also denied there was a time that Resident A blacked out during the incident.

When asked, whether Resident A was ever denied soap or deodorant, Ms. Yancey reported, no. And, she had never heard any residents picking on Resident A, calling him faggot or calling him racial slurs. She also denied calling him a punk or faggot or hearing staff call him such. She said, Resident A was the one calling people names, calling them "bitches".

Mr. Dumas, reported, he responded to a call for assistance that Resident A was threatening to jump over a counter. He, said, Resident A was asked to leave the room; and Resident A threw cards at Ms. Yancey, which went everywhere; then he and Mr. Carter escorted Resident A out of the room. He, said he and Mr. Carter each had one of Resident A's arms, then Resident A got to kicking, and head butting and more, staff, Mr. Washington and Mr. Solomon came. Mr. Dumas, said, Mr. Washington ended up being the one to blind-side swoop, and physically manage Resident A. He said, Resident A is 6' 4", and Resident A was kicking, spitting and trying to punch Mr. Washington. He said, Resident A was also spitting at him, but missing. When asked, whether there was a time that, someone was on Resident legs, Mr. Dumas, said, Mr. Solomon, and Ms. Yancey at one time or another, but not both together. He, said, they (he, Ms. Yancey, Mr. Solomon, Mr. Carter, and Mr. Washington) escorted Resident A to the elevator, but Mr. Washington had Resident A the whole time; and nothing happened on the elevator. He said, Mr. Washington was 6'2" to Resident A 6'4"; and Mr. Washington was the only one able to hold Resident A.

Mr. Dumas denied choking, hitting or punching Resident A, or seeing any staff do so. He indicated, he opened the elevator, and he didn't see any such thing. He also denied Ms. Yancey or anyone saying let's get Resident A on the elevator because there are no cameras. He, said, when they got off the elevator, Mr. Washington still had hands on Resident A, but, he Mr. Carter, Ms. Yancey and Mr. Solomon all walked with them. .

When asked whether Resident A was seen by the nurse, Mr. Dumas reported, when they got off the elevator, the nurse's station was right there, and the nurse tried to assess Resident A, but he wanted to go to his room. Mr. Dumas was not sure if Resident A was assessed later. He, indicated, Resident A wasn't in his group, but he played basketball with him all the time, and he never heard any residents call him faggot, or use racial slurs towards him. Mr. Dumas also denied doing such, or knowing other staff to do so.

Mr. Dumas indicated to his knowledge no staff had ever denied Resident A soap or deodorant. He said Resident A does ask for toothpaste, toothbrushes, and soap more often than other kids, but staff still give it to him.

**Reviewed:**

- Incident reported, which indicated the reason for the physical management.
- Nurses note, which indicated "Upon assessment, no bruises, bleeding, swelling, scratches observed. Full ROM on upper and lower bilateral extremities without difficulties noted at this time."
- Video footage, which showed Mr. Dumas coming out of the room with Resident A, then some struggling, and several staff seeming to be trying to hold Resident A in the hall; then they struggle and seem to all fall. But it was hard to see at that point, who was doing what. At one point Ms. Yancey was also seen standing, and then getting down to the floor with other staff, and up again. A staff identified as, Mr. Burke appeared to stand over them, and Mr. Dumas appeared to get down on the ground, but this Consultant couldn't see what he did or make out what others were doing. From what could be seen, no staff was actually seen kicking or in what appeared to a kick posture. Resident A appeared to get up on his own; then he was escorted to elevator, one staff, identified as Mr. Washington had hands on Resident A, and other staff are with them.

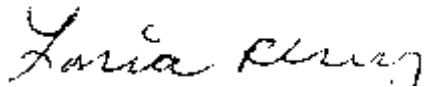
<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of severe physical discipline inflicted in any manner.
<b>ANALYSIS:</b>	The evidence does not support the allegations as reported by Resident A
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (c) Verbal abuse, ridicule, or humiliation.
<b>ANALYSIS:</b>	The evidence does not support the evidence as supported by Resident A
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4168</b>	<b>Personal hygiene.</b>
	An institution shall assure that each resident maintains or receives personal care, hygiene, and grooming appropriate to the resident's age, sex, race, cultural background, and health needs.
<b>ANALYSIS:</b>	Personal hygiene products are available; and are provided the residents for their care and grooming. The evidence does not support the allegations.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.



July 31, 2015

Lonla Perry  
Licensing Consultant

Date

Approved By:



August 3, 2015

Linda Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING

NICK LYON  
DIRECTOR

September 28, 2015

Julie Avant

Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2015C0420044  
Detroit Capstone

Dear Ms. Avant:

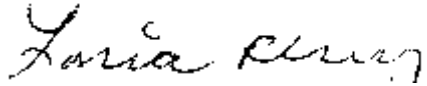
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

A handwritten signature in cursive script, appearing to read "Lonia Perry".

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2015C0420044
<b>Complaint Receipt Date:</b>	07/14/2015
<b>Investigation Initiation Date:</b>	07/14/2015
<b>Report Due Date:</b>	09/12/2015
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2014
<b>Expiration Date:</b>	09/29/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
Resident 1 alleged staff; Kevin Blanks took him to Resident 2's room after residents were down for the evening on Sunday night (July12, 2015); and the two residents fought.	Yes
Additional Findings	No

## III. METHODOLOGY

07/14/2015	Special Investigation Intake 2015C0420044
07/14/2015	Special Investigation Initiated - Letter email to Director, requested incident report, nurses note, inquired if Children Services contacted
07/14/2015	Contact - Document Received email- copies of incident reports
07/15/2015	Contact - Document Received Email-received copy of the complaint from the DHHS Worker
07/15/2015	Contact - Telephone call received Spoke with DHHS Worker
07/16/2015	Contact - Face to Face Interviewed Resident 1 and Resident 2, Spoke with Director, Kathleen Boyes & Program Coordinator, Carita Brown, rec'd nursing note
07/17/2015	Contact - Document Sent Email to DHS Worker
07/21/2015	Contact - Telephone call made Spoke wit Youth Specialist, Kevin Blank
07/22/2015	Contact - Face to Face Interviewed Youth Specialists, Laquint Rhodes, and Michael Floniken, and Resident 3, and Resident 4 along with DHHS Worker
08/01/2015	Contact - Document Sent Email to DHHS -responding to her 7/31/15 email



08/19/2015	Contact - Telephone call received Spoke with DHHS Worker
08/26/2015	Inspection Completed-BCAL Sub. Compliance

**ALLEGATION:**

Resident 1 alleged staff; Kevin Blanks took him to Resident 2's room after residents were down for the evening on Sunday night( July12, 2015); and the two residents fought.

**INVESTIGATION:**

Resident 2, indicated, "They said he let him in my room, but he didn't". He, said, Mr. Blank was walking pass his (Resident 2's)room with Resident 1; he asked Mr. Blank why he had Resident 1; and then Resident 1 ran into his(Resident 2's) room. Resident 2 said, he told Mr. Blank to get Resident 1 out of his room; and Mr. Blank stood there laughing, because Mr. Blank thought they were playing, thought they knew each other, that he didn't know they "were beefing". Resident 2, said, they were in the door; Resident 1 got in his face; he told Resident 1 to get out of his face, and he pushed Resident 1 to get him out. He, said, he told Mr. Blank to get Resident 1, and Mr. Blank did, but that was after they fought, because Resident 1 swung on him (Resident 2), and Mr. Blank tried to break it up. That Mr. Blank pushed Resident 1 to get him out the way, then Resident 2 ran back upon Resident 1. He said, he got hit and punched, three times; and he hit Resident 1 twelve to thirteen times. He said, each time he ran upon Resident 1, he hit him. He, said Mr. Blank, was going back and forth between he, and Resident 1, trying to break them up. When, asked whether, Mr. Blank called for assistance, Resident 2 said, Mr. Blank did not have a "Walkie".

Resident 2, reported the reason he, and Resident 1, were beefing, and fought, was due to them being in rival gangs; and that Resident 1 had fought one of his "brothers". He, reported, he belonged to the CIE (Cash Is Everything) gang; a gang, he made up this year, comprised of about thirty members, located in West Warren. He, said, Resident 1 was in the MVHN (Most Valued Hood Niggars) gang, from west Warren. When, the DHHS Worker asked him if he had any other problems with Resident 1, Resident 2, said, "We be grimacing each other". When asked, whether staff had tried to keep him, and Resident 1 separated, Resident 2, said, yes. He, indicated, he and Resident 1 are in separate groups, but their rooms are in the same area, and they see one another ten to twelve times daily, and they exchange words all the time. Resident 2, said he would fight Resident 1 again, if he got the chance, that "I want my re-match. He blackened my eye." Resident 2's right eye was observed to be darken, and somewhat puffy.

Director, Elizabeth Boyes; and Program Coordinator, Carita Brown, both denied having information that Resident 1 or Resident 2 were in a gang; or that Resident 2 had ever reported being in a gang. Both, indicated, they had tried to figure out why

Resident 2's eye was blacken; but Resident 2 had yet to disclose to them that his eye injury was a result of a fight. They indicated, Resident 2 told them that his injury happened in the gym. Ms. Boyes reported that it wasn't until yesterday (the day before this interview), that Resident 2 told their Clinical Director, Ms. Tracey, it was a gang beef; and he had a thirty-second fight. But, Resident 2, when questioned by them, still denied that his injury happened via a fight.

When asked, whether the two residents were able to get together, have regular contact; Ms. Boyes indicated they aren't. She acknowledged, the two residents are on the same hallway, but said they are on opposite ends; and indicated the two are not in the same group, or school group; and don't come down the hall at the same time. She, said, "We transfer one group at a time" and all transports are fondled through the OCC (Operation Control Center). She, said, the only way they would get together is if someone brought them together. She, indicated, that what Resident 2 reported related to Mr. Blank walking Resident 1 pass his (Resident 2's) room was not feasible; "no way" that's what happened. When asked, as to whether Mr. Blank had a "Walkie, she indicated, he did.

Ms. Brown reported, after she asked Resident 2, and staff about Resident 2's injury, she just happened to be talking with Resident 1; and asked him whether he knew what went on down the hallway where Resident 2 was. She, said, at first Resident 1 said something that didn't make sense; then Resident 1 reported Mr. Blank took him to Resident 2's room, and "we fought". She, reported, when asked why Mr. Blank did that, the resident, reported, Mr. Blank was trying to figure out what was going on with Resident 1 and Resident 2; and he was supposedly trying to do conflict resolution.

Ms. Brown, indicated, Resident 1 had only been at the facility for four days; Resident 2, had been there for a while, but Resident 2 had a history of trying to fight other kids. She, said, after Resident 1 had so casually reported Mr. Blank took him to Resident 2's room; and Resident 2 had said his injury happened in the gym, she looked at the video footage, then sent Mr. Blank home. She, said, the video footage showed Mr. Blank opening Resident 2's door, and Resident 1 going in; and showed Mr. Blank in the resident's door way; but one couldn't see inside the room; and one couldn't see a physical fight between the two residents.

Resident 1 reported being at the facility since the prior week of his interview, with this Consultant, and the DHHS Worker. He, reported, being in Group C, and that Resident 2 was in Group M; and that his room is by the back stairs three doors down on the left; and Resident 2's is on the right side, two doors down in the other direction. Resident 1, reported, he and Resident 2 fought in Resident 2's room; and that Mr. Blank took him to Resident 2's room to fight. He said, residents can hear each other through the doors; and his roommate, Resident 3 was at their door talking with staff that was passing by; and at some point, Resident 2 called out his (Resident 1's) name, and asked whether he had fought his (Resident 2's) friend, who was in a gang, and while Resident 1 was in another placement. Resident 1

said, he responded back to Resident 2 via Resident 3; that he had fought that kid; and when Resident 2 asked who won, he reply back he did, but instead of saying that, Resident 3 said "He beat his ass". Resident 1, said, prior to the night of this incident, he knew Resident 2 wanted to fight him, because a day beforehand, Resident 2 had been beating on his door, and he told him to stop. That Resident 2 had also talked "junk to Mr. Rhodes about him; and he heard Mr. Rhodes ask Resident 2 "What you wanna do, I'll open the door and let you in ". Resident 1, said, Mr. Rhodes opened his (Resident 1's) door to see if Resident 2 had the heart to come in the door. He, said, Resident 2 step forward, then Mr. Rhodes, said "boy go sit down", you not about to fight that boy" Resident 1, indicated, the night of this incident, Resident 2 was talking loudly to Mr. Blank, about him fighting his friend; and Mr. Blank asked Resident 2 what was his beef with him (Resident 1). Then Mr. Blank came to his (Resident 1) door, and asked him what his beef with Resident 2 is. He told Mr. Blank that Resident 2 wanted to fight him, he doesn't want to fight Resident 2, but he would if Resident 2 wanted to, since Resident 2 had beef with him. Resident 1, said, Mr. Blank walked him out of his room, down to Resident 2's room and "popped" Resident 2's door open, and let him in. He said, Mr. Blank had given him instructions that "When you go in there I don't want to hear no whining, no boohooing or hear about no scratches", and Mr. Blank asked him if he understood. He, said, he knew Resident 2 was waiting for him in the room, and he was ok with that; and that when he went in Resident 2 was ready for him. Resident 2 did not have his shirt or shoes on. He said, Mr. Blank said something to Resident 2, and Resident 2 responded "Bet", meaning he was ok with that. He said, he swung on Resident 2, dotted around, swung on Resident 2 again, and hit him in the face. He, said, he and Resident 2 were punching off each other; and that at first they were tussling. He, said, Resident 2 was giving him body shots; and after he hit Resident 2 in the face, they were pushing each other, then he got Resident 2 trapped by the toilet, he was hitting Resident 2, but Resident 2 was covering his face, and Resident 2 wouldn't open up, when he told him to. Resident 1 said, the fight lasted two to four minutes, and he hit Resident 2 three or four times.

When asked, where Mr. Blank was at during the fight, Resident 1 said Mr. Blank was standing outside the door. When asked, how the fight came to an end, and whether Mr. Blank tried to break it up, Resident 1 reported Mr. Blank had not tried to break up the fight. He, said, it got to a point they were both tired; Mr. Blank said stop, and he and Resident 2 stopped. Then, he put his flip flops back on; and left the room. He indicated, after the fight Mr. Blank said, "I'll beat your ass", which Resident 1 indicated, Mr. Blank had said jokingly, because Mr. Blank thought he (Resident 1) had won the fight.

When asked, whether any other staff were around when this situation was happening, Resident 1 indicated, Mr. Floniken was in the group room; but he was not sure whether Mr. Floniken saw anything. He, indicated, Mr. Floniken was in the group room before and after the fight. Yet, Resident 1 thought Resident 2's roommate, Resident 4 saw what happened. Resident 1 reported, before Mr. Blank came to his room, and stated the rules for the fight, he saw Resident 4 come out of

the room, going to the group room. When asked, whether he or Resident 2 had any bruises, Resident 1 reported a couple of scratches. He said, he didn't know he had hit Resident 2 in the eye until sometime later. He said, the next day Resident 2's eye was swollen; and he feels bad about that now. He, said a couple of days after the fight Resident 2 told him "You know I'm the only one to fight you, you know I have heart, give me my perks"; and he did.

Youth Specialist, Keven Blank reported he had been employed at the facility for three months, at that time of the incident. He, indicated, familiarity with the incident, which he said occurred Sunday night, July 12, 2015; and he denied the allegations against him. He said, Resident 1 and Resident 2 (whose name he couldn't recall) who were in rooms two to three door down from one another, were conversing back and forth through doors, saying what they would do to the other. He, said, he asked Resident 2 what was his beef with the new resident, Resident 1; and Resident 2's concern was he knew Resident 1 from JDF, and Resident 1 had fought his friend. He, indicated, he called himself trying to deescalate the situation by finding out from each kid what their beef was with the other; and bringing them together. He, said, he asked, Resident 2, if he got him together with Resident 1 whether he felt he could talk it out, to resolve the situation. Then, he went and asked Resident 1 the same. He, said, after Resident 1 agreed; he escorted Resident 1 to Resident 2's room; and he had Resident 2's roommate, Resident 4 to go to the group room. He said, he stood outside the room; the two boys talked, and nothing happened. He said, this incident happened between 10:00pm- 11:00pm; and the boys talked for about ten minutes, they bumped fists and were ok, then he took Resident 1 back to his room. He, said, there was no fight. He said, Resident 2 was sitting on his bed, when Resident 1 entered, then Resident 2 stood up; he asked Resident 2 a question as to why he was saying he was going to spit on Resident 1, but Resident 1 did not hit Resident 2 in the eye. He, said, when he took Resident 1 back to his room Resident 2 did not have a black eye. When asked, whether there would have been any other opportunity for the boys to get together, whereby they could have fought, like during transport; Mr. Blank said he was not saying that happened, or didn't happen, but it didn't happen in his present. He, said, Resident 1 was in his group, and he thought Resident 2 may have said Resident 1 hit him to get Resident 1 in trouble.

When asked, whether his co-worker Mr. Floniken knew what he was going to do with Resident 1 and Resident 2, he said "No, I don't recall having that conversation with him. When asked, whether conflict resolution was something he was supposed to be doing, Mr. Blank reported it was something that was done by every by staff, from the top staff to bottom level staff. When asked, whether, they had done such conflict resolution in a resident's room, Mr. Blanks said "yes, kid's rooms, conference rooms wherever needed". He, said, "I would have done it in the group room, but it wouldn't have been personal". When asked, if the activity he was doing was sanctioned by the administration, Mr. Blank stated he didn't know. When asked, whether either Resident 1 or Resident 2 said they were in a gang, Mr. Blank, said, they could have been, but it wasn't mentioned.

Mr. Blank, indicated, he found out about Resident 2's blacken eye, and allegations against him the next day. He, said, Team Leader, Ms. Dunlap's had a conversation with Resident 1, and sometime later Ms. Dunlap informed him, Mr. Brown said a complaint had been made against him, and he was to leave the building. He reported knowing Nurse, Gaston had seen Resident 2; and that Resident 2 had reported he hurt himself playing with his roommate Resident 4. Mr. Blank said that was likely, because Resident 2 and Resident 4 were always wrestling. He, believed Resident 2 and Resident 4 were in fact wrestling, and they came up with the story that Resident 2 hurt himself in the gym as cover for what happened; and then they got into a fight was saying he didn't report it, but there was no fight. He said, the boys have told so many different stories about how Resident 2's eye got hurt, who knows what happened. He said, Ms. Brown would have seen him walking with Resident 1 in the hallway, and she would have saw that Resident 1 was not upset, he was calm. And the camera would just be him standing at the door, watching the two boys talk. He, said, administration asked Mr. Floniken, what Mr. Floniken was doing when he came to Resident 2's door, but he(Mr. Blank) didn't know Floniken came to the door, because he was busy listening to the boys.

Youth Specialist, Laquint Rhodes reported not seeing the incident. He said, he did, not work that shift or the day of the incident; and that he did not work with Mr. Blank. He, reported, seeing Resident 2's black eye the next day. He asked, what happened, and at first Resident 2 said his injury happened in the gym playing basketball with Resident 4. Fifteen minutes later, Mr. Rhodes spoke with Resident 2 again; and Resident 2 reported he was fighting with Resident 1 in his room. That Mr. Blank let Resident 1 in his room, and they fought. Resident 2 did not say why Mr. Blank did that. Mr. Rhodes, said, he reported the matter to Ms. Dunlap.

When this Consultant, asked, whether staff were trained in conflict resolution, and would get youths together to work out matters, Mr. Rhodes said, yes; but that it would be done in the group setting, in the nature of an apology, never in the resident's room. Mr. Rhodes was not aware of any incident, whereby a staff had attempted to do such in a kid's room. He also, when asked, indicated Resident 2 had not mentioned he was in a gang, or that the incident with Resident 1 was gang related.

When asked, whether he ever opened Resident 1's door for Resident 2 to go in, Mr. Rhodes denied such. He admitted there was an occurrence whereby those two residents were arguing, exchanging words back and forth; and he intervened. But him opening the door to see if Resident 2 would go in to fight Resident 1, he, said, "That never happened".

Youth Specialist, Michael Floniken reported, being employed with the facility since June 2015. He, reported, being in the Group M's group room, with a resident, when Resident 4 came in. He asked Resident 4 why he was there, and Resident 4 indicated, Mr. Blank told him to step out of his room, while he (Mr. Blank) resolved an issue. But Mr. Blank did not say what the issue was. At some point after that, Mr.

Floniken stated, he heard loud arguing, heard someone say “Nigga I didn’t say that shit”, so he went to investigate. He, said, he looked through the door in search of the arguing, then walked down the hall, and when he went pass the door to Resident 2’s room, it was propped open; and Mr. Blank was in the room with Resident 2 and Resident 1. Mr. Floniken said, he heard talking, looked inside and saw Mr. Blank slanted behind Resident 2 and Resident 1, who were sort of face- to- face; and he only observed that. When asked, whether he inquired what was ongoing on, he indicated he did not, he went back to the group room. He, indicated, ten or fifteen minutes prior he had heard Mr. Blank say, if the boys had issues, he was going to let them talk their issues out. When asked, whether it was evident the boys had issues with each other, Mr. Floniken, indicated no, but Resident 1 had told him Resident 2 didn’t like him (Resident 1) and Resident 1 indicated he was too big to be fighting Resident 2. When asked, whether he had ever seen any staff conduct conflict resolution with youths in their rooms, Mr. Floniken stated he had not, but that he was the new guy. He reported, thinking it was ok since Resident 1 was in Mr. Blank’s group; and he thought Mr. Blank was going to resolve the issue. Mr. Floniken reported, Resident 4 went back to his’ and Resident 2’s room a short time later, as he believed Mr. Blank motioned Resident 4 to come back. When asked, how many kids were in the group room when he left, he indicated there were two; that no other kids were in the room; and that it only took him one to five seconds to go from the group room to Resident 2’s room and back. In terms of the timeframe, regarding the incident, Mr. Floniken, indicated, from the time Resident 4 came into the group room, and when Resident 4 went back to his room, was about one minute. He, indicated, Resident 4, and Resident 2’s room was two doors down from the group room; and Resident 2’s and Resident 1’s rooms are two doors down from one another, slanged on the hallway.

When asked, whether he had any idea what was happening with the boys, he indicated, he didn’t know they were going to fight. He indicated, Mr. Blank manipulated the situation, in that Mr. Blank knew that he was new, and knew he (Mr. Blank) was not to be there, that Group M’s hallway was his’s( Mr. Floniken’ s); and Mr. Blank was supposed to be conducting rounds in Group C. He, indicated, Mr. Blank was disliked by staff, because Mr. Blank was known for leaving his team mates out of ratio. He indicated, had a senior staff like Mr. Wiseman been working opposed to him, Mr. Blank would not have done that.

Resident 4 acknowledged being Resident 2’s roommate; and reported Resident 2 and Resident 1 did not like one another. He, indicated, the two had exchanged words one day, after Resident 2 was beating on the walls, and Resident 1 told him to stop, that that was too close to his room. Then a couple of days, later during med pass Resident 2 was banging on the walls in the hallway; Resident 1’s told Resident 2 to stop, and Resident 2 told Resident 1 to stop talking to him, and said Resident 1 was “soft” and he(Resident 2) would “beat his ass”. Resident 4, indicated, Mr. Blank was walking down the hallway, and Mr. Blank opened his and Resident 2’s door, and asked him “what’s up with those two”. Resident 4 told Mr. Blank about a shower incident; and Mr. Blank asked Resident 2 why he was trying to

fight over that little thing, which Resident 2 replied, he wasn't, and that Resident 1 was crazy. Resident 4, said, the room's door was open when Mr. Blank spoke with then, then Mr. Blank closed it; and went to Resident 1's room to talk with Resident 1. He said, when Mr. Blank came back toward their room, he called to Mr. Blank, and asked if he could go to the group room to get his sandals; and Mr. Blank open the door and told him to hurry up and get them. Resident 4 denied, Mr. Blank told him to leave the room, he, said, he asked to leave to get his sandal. Resident 4, said, he was gone for about one minute, and then he heard tussling and banging coming from his room; he thought someone was banging on the walls, and then he heard another bump; and when he looked in the hallway, he saw Mr. Blank with his (Mr. Blank's) hand on Resident 1's shoulder; and Mr. Blank told Resident 1 to go to his room. Resident 4, denied, seeing Mr. Blank open Resident 1's door to let him in or out, nor did he see Resident 1 open Resident 1's door, though he said he heard Resident 1 say "He's soft".

Resident 4, said, when he went back to his room, Resident 2 was under the covers, and he didn't see Resident 2's face. Then the next day he saw that Resident 2's eye was a little swollen, and black. He asked, Resident 2 what happened; and Resident 2 said he (Resident 4) had elbowed him in the eye while playing basketball. Resident 4, indicated, since that was the same eye (right) that he had elbowed Resident 2 in earlier that day, he thought he (Resident 4) did it. Resident 4 denied seeing Resident 1 and Resident 2 fight, or Resident 2 telling him he (Resident 2) and Resident 1 fought.

Resident 3 admitted to being Resident 1's roommate, but denied knowing about a fight between Resident 1 and Resident 2. He denied there was a time that Resident 1 and Resident 2 were arguing back and forth between the doors, or that he was involved in helping them. He, indicated, Resident 1 never told him he fought Resident 2, or that Resident 2 wanted to fight him (Resident 1). When asked, whether he knew what happened to Resident 2's eye, Resident 3 replied no, then he said, Resident 2, said, a baseball hit him.

**Reviewed:**

- Incident report dated 7/13/15, at 4:30PM that indicated Resident 1 reported that on 7/12/15 he and Resident 2 had a physical altercation in Resident 2's room.
- Nurses, case notes, completed by Nurse Diane Gaston, LPN that indicated on 7/13/15 at approximately 6:30PM Resident 2 "was assessed for being involved in a physical altercation with his roommate. The altercation occurred during the night, but staff did not become aware until later in the day. Resident denied being involved in an altercation; stated to writer he sustained the injury in gym. Assessment revealed right periorbital swelling and bruising beneath the eye. Resident denied having any visual disturbance. Resident also denied having any pain or discomfort. An ice pack was applied to eye".....

- Nurses, case notes, completed by Nurse Diane Gaston, LPN that indicated on 7/13/15 at approximately 6:30PM Resident 1 was assessed for being involved in a physical altercation with his roommate. The nursing case note indicated the same as the reported for Resident 2 with respect to when the incident occurred, and staff becoming aware of the incident. This nurse's note also indicated, "Assessment of hands revealed no visible signs of injury noted." And that that resident denied pain or discomfort.
- Video footage that showed: At 9:23-01PM Mr. Blank took Resident 1 from his room and escorted him down the hall to a room identified as Resident 2's. Resident 2's door was cracked, and Mr. Blank's back was seen in the door room window. What was occurring in the room was not visible via the camera footage. 9:23-16PM Mr. Floniken walked to Resident 2's door, looks in and returned back down the hallway. 9:23-43PM Resident 1 exited Resident 2' room, and went down the hall, then at 9:23-51PM Mr. Blank exited Resident 2' room; went down the hallway; and at 9:23-54PM, Mr. Blank unlocked Resident 1's room, Resident 1 entered, and Mr. Blank closed the door. Resident 4 was also seen exiting the group room and Mr. Blank took Resident 4 to his room.

<b>APPLICABLE RULE</b>	
<b>R 400.4112</b>	<b>Staff qualifications.</b>
	(1) A person with ongoing duties shall have both of the following: (a) Ability to perform duties of the position assigned. (b) Experience to perform the duties of the position assigned.
<b>ANALYSIS:</b>	Mr. Blank took Resident 1 from his room, in the middle of the night, into Resident 2' room for what he reported was a conflict resolution attempt to have the two residents resolve their differences; and Mr. Blank's he did not inform the other staff of his intentions nor was his actions authorized by the facility for the manner in which Mr. Blank did so. And although the evident is convoluted in terms of whether the two residents fought, in the matter in which Resident 1 described; given the two residents prior negative behavior with one another, the potential for a physical altercation existed and Mr. Blank placed both residents at risk; and he did not demonstrate adequate ability and experience to perform his duties at the time.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

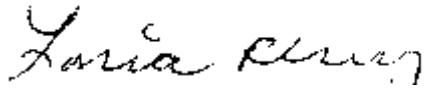
<b>APPLICABLE RULE</b>	
<b>R 400.4137</b>	<b>Discipline and behavior management.</b>
	(3) Residents shall not be permitted to discipline other residents, except as part of an organized therapeutic self-governing program that is conducted in accordance with written policy and



	is supervised directly by designated staff.
<b>ANALYSIS:</b>	<p>Mr. Blank reported he was in Resident 2's room with Resident 1 for about ten minutes, and camera video showed the length of time he and Resident 1 was observed to be inside of Resident 2's room was about a minute. And although it is questionable whether the latter indicated time was enough time for the two youths to engage in the type of physical altercation that Resident 1 described; it is enough time for swings to be thrown, and for Resident 2 to be punched by Resident 1. Resident 2 described the incident to his therapist, as a thirty second fight.</p> <p>And although Mr. Blank reported he was attempting conflict resolution when he took Resident 1 to Resident 2' room; his actions enabled the two residents to engage in a physical encounter, in an attempt to punish one another.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptance corrective action plan, continuation of the facility's current licensing status is recommended.

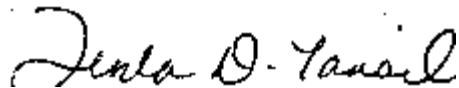


September 24, 2015

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



September 28, 2015

\_\_\_\_\_  
Linda Tansil  
Area Manager

\_\_\_\_\_  
Date



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING

NICK LYON  
DIRECTOR

September 20, 2015

Julie Avant  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2015C0420047  
Detroit Capstone

Dear Ms. Avant :

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

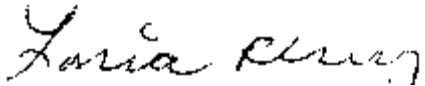
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

-

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

A handwritten signature in cursive script that reads "Lonia Perry".

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2015C0420047
<b>Complaint Receipt Date:</b>	07/22/2015
<b>Investigation Initiation Date:</b>	07/23/2015
<b>Report Due Date:</b>	09/20/2015
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2014
<b>Expiration Date:</b>	09/29/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
Resident A alleged she was attacked by a staff on the girls' unit	Yes
Additional Findings	No

## III. METHODOLOGY

07/22/2015	Special Investigation Intake 2015C0420047
07/23/2015	Special Investigation Initiated - Telephone Spoke with DHS Worker
07/31/2015	Contact - Face to Face Interviewed Resident A, Youth Specialist, Arielle Chisholm, Resident B, Resident C, and reviewed video footage with DHHS Worker
08/01/2015	Contact - Telephone call made Left message for Youth Specialist, Tiffany Chappell
08/01/2015	Contact - Telephone call made Spoke with Youth Specialist, Ebony Dunlap
08/01/2015	Contact - Telephone call made Spoke with Youth Specialist, Valerie Williams
08/01/2015	Contact - Telephone call received Spoke with Youth Specialist, Tiffany Chappell
08/03/2015	Contact - Telephone call made Spoke with Youth Specialist, Antonio Dumas
08/03/2015	Contact - Telephone call made Spoke with Youth Specialist, Ms. Purify
08/03/2015	Contact - Document Sent Email to Director
08/03/2015	Contact - Document Received Email from Director
08/03/2015	Contact- Telephone call Made Spoke with Director RE Special investigation

08/25/2015	Inspection Completed-BCAL Sub. Compliance
08/25/2015	Contact - Telephone call made Phone conf. spoke w/DHS Worker and his Supervisor

**ALLEGATION:**

Resident A alleged she was attacked by a staff on the girls' unit

**INVESTIGATION:**

<b>APPLICABLE RULE</b>	
<b>R 400.4112</b>	<b>Staff qualifications.</b>
	(1) A person with ongoing duties shall have both of the following: (a) Ability to perform duties of the position assigned. (b) Experience to perform the duties of the position assigned.
<b>ANALYSIS:</b>	
<b>CONCLUSION:</b>	VIOLATION ESTABLISHED

<b>APPLICABLE RULE</b>	
<b>R 400.4158</b>	<b>Discipline.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of corporal punishment inflicted in any manner. .
<b>ANALYSIS:</b>	
<b>CONCLUSION:</b>	VIOLATION ESTABLISHED

**IV. RECOMMENDATION**

Upon receipt of an acceptance corrective action plan continuation of the facility's current licensing status is recommended

*Lonia Perry*

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Lonia Perry  
Licensing Consultant

Date

Approved By:

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Linda Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING

NICK LYON  
DIRECTOR

September 29, 2015

Julie Avant  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2015C0420049  
Detroit Capstone

Dear Ms. Avant:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required; but based on actions already taken; no further corrective action plan is required.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure



**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2015C0420049
<b>Complaint Receipt Date:</b>	08/06/2015
<b>Investigation Initiation Date:</b>	08/24/2015
<b>Report Due Date:</b>	10/05/2015
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2014
<b>Expiration Date:</b>	09/29/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
It is alleged the staff Ms. George called Youth A a fat ass	Yes
Additional Findings	No

## III. METHODOLOGY

08/06/2015	Special Investigation Intake 2015C0420049
08/24/2015	Special Investigation Initiated - Face to Face Spoke with Program Coordinator, obtained Youth A's grievance report
08/24/2015	Contact - Face to Face Interviewed Supervisor Alicia Yancey, obtained write up on staff, Ms. George- Madison
08/28/2015	Contact - Face to Face Spoke with Youth A
08/28/2015	Contact - Telephone call made Left message for Youth Specialist, Latonya- George-Madison
09/09/2015	Contact - Telephone call made Left message for Ms. George- Madison
09/09/2015	Contact - Telephone call received Spoke with Ms. George- Madison
09/09/2015	Inspection Completed-BCAL Sub. Compliance
09/22/2015	Comment- Exit

### ALLEGATION:

It is alleged the staff Ms. George called Youth A a fat ass.

### INVESTIGATION:

Supervisor, Alicia Yancey, indicated, familiarity with the incident. She, reported that on August 1, 2015, Team Leader, Ms. Jones informed her that Youth A, said Ms. George called her out of her name. Ms. Jones asked her (Ms. Yancey) to address the issue, when she came in to work. Ms. Yancey, indicated, the youth reported the matter to the staff on August 1, 2015, but the youth had also written a grievance, and

put it in the grievance box. Ms. Yancey did not speak with the youth; and she wasn't sure if the Quality Assurance Representative, Ms. Henderson had obtained the grievance, at that time it came to her (Ms. Yancey) attention. She, said, Ms. Henderson called her on or about August 5, 2015, and she told Ms. Henderson she had already addressed the matter. Ms. Yancey, reported, she spoke with Ms. George, and Ms. George said, she made an inappropriate comment to Youth A, but Ms. George, said she didn't use profanity. Ms. Yancey, said, Ms. George wouldn't say what the inappropriate comment was; but she advised Ms. George that speaking inappropriately to residents was against the rules. She gave Ms. George a verbal warning.

When asked, whether any other resident had accused Ms. George of talking negatively to them or being verbally inappropriate, before, Ms. Yancey, indicated, no one had indicated such to her.

Youth A (17) reported Ms. George, and Ms. Baugh were making fun of her weight; that Ms. George called her and her old roommate "fat asses". Youth, A said, she couldn't recall the issue that was happening, but she wrote a grievance. She, said, Ms. George was irritated with her, and she told Ms. George she didn't need to be here if she wants to harass kids. She, said, she told her therapist about Ms. George, but she did not recalling tell a supervisor. Youth A, said, since the incident, she has kept her distance from Ms. George, but Ms. George has tried to talk with her nicely.

Youth Specialist, Latonya George- Madison (AKA Ms. George) initially, indicated she did call Youth A a name; and Ms. Yancey spoke with her about. When asked, what happened, Ms. George, indicated, she and Ms. Baugh were giving out jumpers, and sanitary care items to the female residents; and she told Youth A the jumper she had on was too small for her. She, said, Youth A, said "What are you trying to call me, a fat ass". Ms. George, said, she told the youth no, that's not what she was trying to call her, that she was just saying you need another size, because that one was too tight. Ms. George, said, she ended up getting a verbal warning for the incident, and she accepted it. When asked, did she make an inappropriate comment to the youth, she said "True but it was a derogatory statement". When asked, what the derogatory statement was, Ms. George, said "I said she should go up a size". When asked, why would she accept a disciplinary action for just saying that, Ms. George, stated, because it was a verbal warning. When this Consultant apprised Ms. George that a verbal warning still got written in her personnel record; so why would she agree to a disciplinary action, if she had not called the youth a "fat ass" or said an inappropriate comment; Ms. George stated, because she thought about how Youth A took it. That for the youth to go, and talk to Ms. Yancey, "I felt that maybe I had hurt her feelings, and was calling her fat".

**Reviewed:**

- Employee Corrective Action Notice for Latonya George-Madison dated August 5, 2015; signed by Ms. George, Ms. Yancey, and other administrative staff.
- Grievance form from Youth A dated July 25, 2015, that indicated, Ms. George called Youth A and another female resident “some fat asses” because they were questioning why they had to change out of their pant. That they gave Ms. George a little attitude and that frustrated Ms. George, and that’s when she called them out of their name.
- Facility Discipline policy, which indicated DBI-Capstone prohibits the following discipline “ The use of demeaning, shaming or degrading language or activities

<b>APPLICABLE RULE</b>	
<b>R 400.4109</b>	<b>Program statement.</b>
	(1) An institution shall have and follow a current written program statement which specially addresses all of the following:  (c) Policies and procedures pertaining to admission, care, safety, and supervision, methods for addressing resident’s needs, implementation of treatment plans, and discharge of residents.
<b>ANALYSIS:</b>	Ms. George did not adhere to the facility’s policy, she used a derogatory statement to call the youth fat.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

The staff received a written verbal disciplinary action related to her conduct; and based on the action already taken by the facility; no further corrective action plan is required.

Continuation of the facility’s current licensing status is recommendation. Staff sensitivity training is also strongly recommended.

**Septemeber 27, 2015**

_____ Lonia Perry Licensing Consultant Approved By:	_____ Date
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**September 28, 2015**

_____ Linda Tansil Area Manager	_____ Date
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RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING

NICK LYON  
DIRECTOR

April 4, 2016

Julie Avant  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2016C0420010  
Detroit Capstone

Dear Ms. Avant:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B

51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2016C0420010
<b>Complaint Receipt Date:</b>	12/29/2015
<b>Investigation Initiation Date:</b>	01/05/2016
<b>Report Due Date:</b>	02/27/2016
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	1ST PROVISIONAL
<b>Effective Date:</b>	01/25/2016
<b>Expiration Date:</b>	07/24/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE



## II. ALLEGATION(S)

	Violation Established?
While being restrained on 12/27/15 Youth A received a gash above his left eye and was taken to the hospital where he got stitches.	No
Youth A received an injury to his chin due to a restraint by staff	No
Youth A's testicles were groped by a staff	No
Additional Findings	Yes

## III. METHODOLOGY

12/29/2015	Special Investigation Intake 2016C0420010
01/05/2016	Special Investigation Initiated - Letter Email to Quality Manager, Ms. T Henderson, RE her 12/29/15 email about incident- Requested hospital document requested
01/05/2016	Contact - Document Received Hospital document
01/11/2016	Contact - Face to Face Interviewed , Youth A, Team Leader, Ebony Dunlap, and PM Shift Program Coordinator, Patricia Sims
01/19/2016	Contact - Face to Face Spoke with Quality Assurance Manager, Taneisha Henderson, interviewed Youth A Specialists, Bernard Tyler, Allan Vaughn, and vide video
01/25/2016	Contact - Telephone call made To Youth Specialist, Henry Simmons
01/25/2016	Contact - Telephone call received Spoke with Henry Simmons
01/25/2016	Contact - Telephone call made Spoke wit Youth Specialist, Donavon Harper
01/25/2016	Contact - Telephone call made Spoke with Youth Specialist Denolius Burkes
01/26/2016	Contact - Telephone call made Spoke with Youth Specialist, Gary Solomon
01/26/2016	Inspection completed Sub. Compliance

**ALLEGATION:**

While being restrained on 12/27/15, youth A received a gash above his left eye; and was taken to the hospital where he got stitches.

**INVESTIGATION:**

The complaint document indicated the above allegation; as well as, that youth A was restrained after assaulting staff members, punching windows, and trying to destroy property; and that he was restrained by Allen Vaughn. It also indicated other staff members were present, however their names were unknown; and that there was video footage which showed youth A behaving wildly; which caused he and Mr. Vaughn to fall.

Youth A(17), a resident in the facility's Horizon program, placed out of Nevada, indicated, he was pissed off; he tried to swing on a staff, he thought was Mr. King; and Mr. Vaughn ran up to him. He, said, Mr. Vaughn thought he was going to hit him, and Mr. Vaughn grabbed him, and threw him to the floor. He, said, Mr. Vaughn used two hands when he grabbed him; and when he (youth A) felt, he landed on his face, then Mr. Vaughn took the back of his (Youth A's) head, smashed it into the floor, more than twenty times; and blood was everywhere. Youth A, said there was puddle of blood; and he went to the hospital; and he received twenty stitches and two staples. (Youth A's had a visible healing wound above his eye). He, said, two days prior to the interview with this consultant, he got hit, accidentally, while playing basketball, in the same eye; causing his stitches to come out; and he went back to the hospital for re-stitching.

Youth A, reported, he also got seven stitches to his chin, when he got injured about twelve days ago, during the morning shift; when he was, fighting staff, Mr. Tyler, whom he said grabbed his nuts. He, said, Mr. Tyler and Mr. Simmons, who was telling him to calm down, came after assistance was called for. He, indicated, he walked out of his class, after being told to sit down, but he didn't listen. He, said, when he left, Mr. Harper followed him to the hallway, where he was kicking a door. He, indicated, while he kicked the door, Mr. Harper egged him on, saying "Kick the door little bitch, kick the door little bitch, so I can hurt you more". When asked if he knew what Mr. Tyler meant, youth A said, "like slam you"; but he admitted Mr. Tyler did not say that. He, said, then, Mr. Harper restrained him. When asked if the restraint was proper, youth A said "yes, but to me, no". He, said, he was kicking the wall; and Mr. Harper placed him on the wall, where his arms were locked in front of him; and Mr. Harper slammed his (Youth A's) face into the wall. He, indicated, when he was slammed, his eye opened up again, and his chin got injured; and blood was on the wall, and he went to the hospital and got stitches.

Youth A, said, this incident happened by the elevator, and Mr. Tyler, Mr. Harper, Mr. Simmons and Ms. Jones were the staff members involved. It is noteworthy that

some of youth A's statements were not coherent, he got confused when trying to explain chain of events of the incidents, and timeframes.

When asked if staff walked him to the elevator, when some of what he reported occurred, he said, yes. He, said, it was Mr. Tyler who walked him to the elevator. Then, he said, he couldn't remember. When asked whether any other residents witnessed the incident, youth A, said, no. When asked whether anyone witnessed Mr. Tyler grab his nuts; he said Ms. "Cap"( name and spelling, not sure of) restraints). He, said, Ms. "Cap" told Mr. Tyler "You're not allowed to grab his nuts"; and that Mr. Tyler responded "He's almost a man, and he's fighting with one of my good staff, and I have to do something". And "Ms. Cap, said that's not right".

Team Leader, Ebony Dunlap, was asked about youth A's eye injury noted in the complaint; and the one this consultant saw to youth A's chin. Ms. Dunlap reported there were two separate incidents. She, indicated the chin incident occurred a couple of days after the eye injury. She, said, the first injury occurred on the day shift, so she was not sure how it happened, but that he had reopened his eye twice since, and then his chin, and that this were due to him self- harming or self-injuring those areas. She, said, he had gone to the hospital three days in a row after the first injury to the chin; and that those hospital visits were on different shifts. She, indicated, she spoke with youth A after he went to the hospital after his first chin injury; and he said he was going to keep hurting himself, and reopening his wounds, because he liked going to the hospital. She, indicated, due to that, on her shift, if youth A had to be restrained she had staff to place something soft under him to stop him from reopening his eye, and chin.

Ms. Dunlap, indicated she was involved in youth A's restraint on 12/27/15, but Mr. Tyler was not; and she was not aware of him grabbing youth A nuts. She, said, she knew there was a time youth A had grabbed staff, Mr. Solomon's testicles; and Mr. Solomon told youth A he couldn't do that. She, indicated, Mr. Vaugh was involved in the restraint with her, but he didn't do anything to youth A. She, indicated, just before youth A was restrained, he, out of the blue, punched a peer; the two residents were separated; and he was placed in a group room with three other kids. He, said, he was doing ok, until the kids began talking about the incident that had just occurred; and the kids were advised to stop, but youth A got upset; and walked out of the group room. Ms. Dunlap, said, she went behind him, and she had the three other residents to step out in the hall, because she couldn't leave them in the room. She, indicated, since youth A liked kicking doors, he hit the wall; and started kicking a door. She, indicated while she was trying to deescalate youth A, youth B, and youth C (two of the three kids, she had in the hall with her for supervision, while awaiting Mr. Singleton's return, whom she reported relieving, so he could take a bathroom break); came down and advised youth A to stop and chill respectively. She, indicated after youth B's comment, youth A stopped, but then youth A punched the light fixture in the ceiling; and then when youth C told youth A to chill, youth A walked to the other end of the hall and she followed him. She, indicated, Nurse Hinton had come down the hall, and she asked Nurse Hinton to escort the other

three residents back to the group room. She, indicated, she was still trying to deescalate youth A; but he hit the ceiling and broke the light fixture due to grabbing on it. She, indicated, youth A to be a very big kid; and she was trying to deescalate him, trying to avoid having to restrain him prior to male assistance coming. But, after youth A picked up a broom (left by Ms. Singleton, because he was going to clean) and waved it at her and threatened to 'whipped his peer's ass", she grabbed the broom; and then youth A snatched the vent out of the ceiling; and she attempted to restrain him, to stop him from going into the group room. She, said, youth A was whaling around in her grip, but she was able to get him to the corner. She, said, the kids in the group room were able to see what was going on; and youth B somehow pushed passed nurse Hinton, and got into the hallway, and threatened youth A, telling him if he hurt her he was going to "F him up". She, said, by that time, Mr. Vaugh and Mr. Simmons arrived; Mr. Simmons took youth B back to the group room; and Mr. Vaugh tried to deescalate youth A. She, indicated, when, Mr. Vaugh asked youth A what was wrong, youth A swung on him, and maybe hit Mr. Vaugh in the chest; and Mr. Vaugh stepped back; and attempted to place youth A in a PRT (physical restraint technique). She, indicated, doing such was difficult, because youth A "was just so strong," and he was grabbing and pinching Mr. Vaugh's side. Ms. Dunlap, said, she tried to assist Mr. Vaugh by straightening the youth's arms, so Mr. Vaugh "could get his hooks in" and restrain youth A. She, said, then, Mr. Simmons, yelled from the group room that they needed to take youth A to floor; and they attempted to do so. She, said, they didn't really have him, because he was kicking; and Mr. Vaugh may have had one of youth A's arm; but she wasn't sure. And that, after Mr. Simmons said what he did, she told Mr. Vaugh she was about to get youth A's legs; and youth A began kicking; and then youth A, and Mr. Vaugh fell. She, said, Mr. Vaugh fell on youth A's back, who fell face down. She, said, once down, she got on youth A's legs, and Mr. Vaugh was able to retain his grip on youth A's arm, when they fell, but she could not recall how Mr. Vaugh was holding youth A. She, indicated, then Mr. Simmons, said, "He's bleeding or who's bleeding", and that caused youth A to become more upset; and he was whaling around more. Then Mr. Simmons came out to assist, because youth A had somehow gotten loose; and so, Mr. Simmons; and Mr. Vaugh were on each side of youth A. But then Mr. Vaugh, said "he's biting me; and Mr. Vaugh stood up. Ms. Dunlap was not sure if youth A had let Mr. Vaugh go, or if Mr. Vaugh snatched his arm away. She, indicated, she and Mr. Simmons continued the restraint; and Mr. Vaugh left the hall/area. She, said, when youth A realized the blood was his', he calmed some; and she and Mr. Simmons got him up, and escorted him to the behavioral modification room (BMR).

Ms. Dunlap, said, the nurse assessed youth A, and advised he needed to be sent out to the hospital for his eye. She, said, then on 1/3/16 during the AM shift, youth A became upset over losing a good day; and he began stomping a phone he snatched off the wall; and he was "swooped"/restrained by Mr. Brit, who took him to the wall. She, said, Mr. Brit was encouraging youth A to calm down; and youth A apparently heard her calling for staff assistance, and he began to struggling more in the restraint. She, said, youth A was trying to get loose; and he and Mr. Brit A moved about the floor; fell on the couch, and Mr. Brit lost his grip. She, indicated youth A

was actually on the couch, and Mr. Brit was leaning over the couch with one knee on the floor; and youth A swung on him, at which time, staff assistance arrived, via, Mr. Blue, Mr. Solomon, Mr. Burke, and the on call therapist; and youth A was restrained. She, said, somehow, youth A ended up on the floor, with his face down; and he banged his face on the floor at least twice; and his chin was bleeding. She, said, therapist directed Mr. Solomon to put his hand under youth A's chin, which he did; and Mr. Solomon was able to get youth A calmed. Thereon, youth A was taken to the BMR; and, he said, he wanted to go to the hospital; and once he was assessed by the nurse, the nurse indicated she could not see youth A's stitches; and he was taken to the hospital.

Afternoon Shift Supervisor, Patricia Sim did not recall being involved in either of the incidents with youth A, but recalled him being sent out to the hospital seemingly every other day, due to him self-harming or doing something to reopen the injury to his eye and, or chin. She, said, he had literally sat and banged his face; and that he had repeatedly indicated "I don't want to be here" or that he wanted to go home, or go back to jail; and that he didn't care what he had to do to get out of here.

When asked whether youth was also injured by being hit by a basketball; Ms. Sims and Ms. Dunlap, both acknowledged that to be true. Ms. Sims indicated, the staff supervising the group was disciplined; because the Director, felt the staff should have been more mindful to not have youth A participate in sports. Ms. Sims, reported the incident was an accident; and she acknowledged youth A had not been placed on a no sport's list, by the medical staff, at that time; but he was now.

Quality Assurance Manager, Taneisha Henderson, reported youth A is a cognitively impaired youth, who is placed in the facility's Horizon program. She, indicated, he typically gets confused about things; and he had repeatedly indicated to staff that he wanted to go to the hospital; and that he will keep self-harming to do such. She, said, staff had been doing all to closely monitor him, that he is on 1:1 supervision at reflection time, and bedtime (times he is in his room); but he continued to have incidents. She, reported receiving no grievance from youth A related to the allegations of mistreatment by staff.

Youth Specialist, Patricia Jones, recalled an incident where youth A injured his chin. She, indicated, when she came on the scene, the restraint was over; and youth A was in a calm position; and she saw blood on youth A's chin; and on the floor. She reported, youth A had kicked a door open; which she admitted she didn't personally see, that she saw it on camera later; and he was restrained, by Mr. Dawson and Mr. Harper. She, indicated, she, Mr. Solomon; and the on call therapist came after; along with the nurse. Ms. Jones indicated, she was not involved in or connected to an incident where youth A's injured his eye. She, indicated, this incident, where she recalled youth A's chin bleeding was one to two weeks prior to the interview with this consultant.

Youth Specialist, Roxanne Dawson, indicated, youth A kicked opened a maintenance room door, ran inside, picked up an item; and he was physically managed by Mr. Harper. She, said, Mr. Harper was walking with the youth, then took him to the wall; and youth A was being aggressive and banged his head against the wall. She, said, she told Mr. Harper to take youth A to the floor, because she wanted to ensure youth A was away from the wall; and that youth A couldn't keep banging his head. Ms. Dawson, indicated, she held youth A's legs, and Mr. Harper sat youth A down. She, said youth A was saying he wanted to reopen his stitches on his chin, so he could go back to the hospital. When asked whether youth A reopened his injury, and whether there was blood; Ms. Dawson, indicated yes; and she assumed he injured his chin; because when she reached up near his face, blood dripped on her gloves. Ms. Dawson reported being unaware/not involved on an incident where youth A sustained an injury to his eye.

Youth Specialist, Bernard Tyler, was not sure whether he was involved with the incident where youth A's eye or chin was injured. He, indicated, he may have been called on the scene for assistance, but he could not recall specifics. He, said, youth A was always bleeding; that every time youth A had to go to the BMR it was because youth A had reopened an injury. He, indicated, all the restraints blended together.

Mr. Tyler, did recall an incident /restraint in late December 2015, where, he, seven staff were involved on; but he could not recall all the staff. He, recall a Mr. Peter was on youth A's legs, but he could not recall whether youth A received an injury. He, also, recalled another restraint in youth A's room involving Ms. Jones and Mr. Carter, but could not recall the circumstances surrounding the restraint, but recalled restraining youth A and taking him to the BMR. When asked whether doing either one of those incidents/restraints, whether he touched youth A's testicles, or if his hands came near youth A's groins area, Mr. Tyler denied such; and reported not knowing why anyone would report he had.

Youth Specialist, Allan Vaughn, indicated, he did not work with the Horizon group; but he recalled an incident with youth A in December 2015, with Ms. Dunlap. He, said, he responded to a call for assistance; and when he arrived, Ms. Dunlap was in the hallway with youth A trying to separate youth A and youth B. He, said, after youth B was taken in the group room; he( Mr. Vaughn) tried to give support and encouragement to youth A, who was irate and upset; and youth A swung on him; and he initiated the restraint, and Ms. Dunlap assisted. He, said, youth A was struggling; and youth shook one of his arms free; but he grabbed it, and enabled Ms. Dunlap to grab it; and they were taking youth A to the ground. He, said, they tried to place youth A in the settle position; but youth A was moving frantically, and they ended up falling. He said, he ended up falling on top of youth A; and while he was trying to adjust himself, and set youth A up; youth A bit him on his right forearm( an old healing bite mark was visible on his arm) ; and Mr. Simmons stepped in and restrained youth A on the floor.

When asked if when they fell, whether youth A injured his eye, at that time; Mr. Vaugh reported being unsure. He, said, youth A was sought of on his side; and he couldn't see anything. Nor did he notice any marks or bruises to youth A at that time; but he did recall seeing "a little bit of blood on the floor" before he switched out with Mr. Simmons in the restraint. He reported, learning after youth A returned from the hospital, that youth A received stitches; and so he surmised youth A must have hurt his eye, because youth A "fell fast and hard". Mr. Vaugh denied slamming youth A to the floor or smashing youth A's head to the floor; and he did not recall any other incident with youth A. He, said, after youth A's self-harm incidents, youth A was placed on 1:1 supervision. He, said, there had been four to five times where youth A, out of the blue, had gone up to a kid and just hit the kid, to get the youth to fight or hit him; and it was him who usually tried to calm the other kid; and his partner calmed youth A. He said, youth A had since apologized for biting him; but Mr. Vaugh was unsure why anyone would report he had injured youth A.

Youth Specialist, Henry Simmons recalled youth A injuring his eye, not his chin. He said, he, and Mr. Vaugh responded to a call for assistance; and when they got there, youth A was in a corner in the hallway. That Ms. Dunlap was holding youth A back; and youth B ran up on youth A, and he (Mr. Simmons) grabbed youth B, and placed youth B in the group room. He, said Mr. Vaugh swooped youth A, tried to place youth A in a blind-side swoop; and the two ended up falling on the floor, face downward. Mr. Simmons was not sure if either one of them fell on the other, but indicated, he ran over and assisted Mr. Vaugh; because, Mr. Vaugh stated "he's biting me"; and Mr. Vaugh had a bite in his arm. Mr. Simmons, said, when they lifted youth A up he noticed blood on the floor, and saw blood on youth A's face. He indicated, youth A was still, struggling, and cursing, at that point, and saying he didn't want to be there. Mr. Simmons, reported Mr. Vaugh never threw youth A to the floor, nor smashed youth A's head to the floor. He, said, when youth A, and Mr. Vaugh fell, he ( Mr. Simmons) was at the group room door, and he could see that youth A was twisting in an attempt to get loose; and when they fell, youth A twisted around enabling him to bite Mr. Vaugh.

Youth Specialist, Donovan Harper, reported not being involved in any incident where youth A's eye was incident. He, indicated when he came to work one day, he noticed youth A had stitches to his eye area; and youth A said he got into a fight with another resident. Mr. Harper, indicated, a few days later, he was involved in a restraint with youth A, after youth A was damaging and attempting to destroy property, by hitting the light fixtures, and punching the ceiling. He, said, youth A refused his repeated instructions to stop, entered a maintenance room; and he called for assistance. He, said, Ms. Dawson arrived; and he and she grabbed one of youth A's arms, and were escorting him to down the hall, but then youth A started to struggle; and the escort turned into a full restraint. He, said, he had youth A's arm hooked, but youth A ran into the wall; and youth A's stomach and chest hit the wall, but he wasn't sure, at that time, if youth A hit his face. He, said youth A was still yelling and fighting; but he was able to get youth A to the floor. He, said, he was behind youth A; and Ms. Dawson was on youth A's leg. He, said, another staff,

maybe, Mr. Solomon switched out with him since youth A's upset was directed at him (Mr. Harper); and he (Mr. Harper) left the floor.

Mr. Harper, denied egging youth A on, telling youth A to do anything but calm down. He, also denied slamming youth A's face to the wall, threatening him or calling the youth out of his name. He, indicated, he was around other staff, so why would he do that. He, indicated, even when youth A grabbed his scrotum, he never "broke character" or called the youth out of his name. He, said, the, new therapist, shouted out how youth A had grabbed his scrotum/ groin area, and told youth A he couldn't do that. Mr. Harper, said Mr. Burkes, intervened and removed youth A's hand from his groin area. Mr. Harper, indicated that was what youth A did, meaning that whenever youth A got into a restraint he couldn't get out of, youth A grabbed a staff's body part; or would pinch the person's side.

Youth Specialist, Denolius Burkes, could not recall involvement in any incident where youth A's eye was injured. He said, "I don't work with that group". But, he, recalled, responding to a call for assistance to a math class; and once he arrived, the staff, whom he could only recall Mr. Harper, had youth A in the restraint. Mr. Burkes, indicated he did not observe any staff hitting, kicking, slamming or doing anything improper or malicious to youth A. He, did recall noticing that youth A's chin, and eye were bleeding; but indicated that may have been the third or fourth time, he had seen youth A's eye or chin bleeding. He, indicated, at the time of that particular incident, the therapist, whose name he couldn't recall, used a towel on the youth's injuries; and the nurse came and attended to the youth.

When asked whether he saw youth A grab a staff's testicles, or groin area, or saw a staff to grab youth A's, testicles or groin area, Mr. Burke, indicated, he did not. He, indicated, he had heard that youth A would; that youth A would grab that body part if youth A couldn't get out of a restraint.

Youth Specialist, Gary Solomon, indicated, familiarity with youth A; indicated youth A was in his group. He, said, youth A got restrained all the time; but he denied being in an incident where youth A's chin was injured; but he recalled going to the hospital with youth A. He said, youth A said he (youth A) hit his chin on the wall.

Mr. Solomon recalled involvement in an incident where youth A reinjured his eye. He, said, when he arrived on the scene youth A was self-harming, hitting his head on the ground, blood was on the floor, and youth A was saying he wanted to go back to the hospital. He, said, the restraint was already happening when he got there; and he tried to put paper towel on the floor so as to soak up the blood; but he denied seeing any staff harming youth A.

### **Reviewed**

- An incident report dated 12/27/15 for 3:30PM; that indicated youth A, without warning, upon entering the group, hit his peer; and the two residents were separated. That youth A got upset, left the group room, and began hitting and



- punching property, would not respond to staff's attempts to deescalate; and youth A attempted to punch staff ; that a struggle ensued; and the youth and staff fell to the floor, and youth A hit his face on the floor. That youth A was physically managed then and he bit the staff. That upon assessment by the nurse it was determined that youth A needed to be sent to the hospital; he had sustained a gash to his eye. The Nursing section of that incident report indicated youth A was observed to have a three centimeter gash located to the left eyebrow line, along with two small scratches to the back of his neck.
- A 12/27/15 facility's Medical encounter form for youth A that indicated "Gash over left eye" and referred the reader to see that attached. The attached was hospital discharge instructions that indicated youth A had a laceration that was closed with absorbable stitches. The number of stitches was not indicated. Though it is noteworthy, the then Director, Mr. Whitlow, reported youth A received nine stitches, and no staples. The discharge instructions also indicated the youth had contusions (bruises) to be treated by ice pack and ibuprofen.
  - A 1/3/16, incident report for 11:40PM that indicated youth A was agitated, attempted to break a telephone; and youth A was restrained; and during the restraint youth A was combative, and aggressive with staff, That they struggled; and youth A fell to the floor during the physical management, reopening an old wound.
  - A 1/4/16, incident for 9:40Am report that indicated the writer/nurse was called to assess youth A due to him being physically managed; and the nurse observed the resident standing in the basement with the staff nearby (Mr. Harper was the staff named on this incident report); and youth A had a "slash on the right side of his chin". That youth A denied any discomfort or pain; and was sent to "Receiving" hospital and returned.
  - A 1/5/16, 4:50PM incident report that indicated youth A, after running out of a group room, got into another room, then was physically managed. And that upon assessment by the nurse, he was observed to be bleeding from his wound to his chin that had stitches, That the wound was reopened; it was cleaned and attended to; and the doctor was contacted, and youth A was being sent to Receiving hospital for evaluation.
  - A 1/14/16, 11:40AM incident report that indicated youth A was involved in a physical altercation with a peer, where he was struck in the face; and upon the nurse's assessment, an old laceration on youth A's left eye was noted to be reopened.
  - Video footage for the incident on 12/27/15 involving Ms. Dunlap, Mr. Vaughn, and Mr. Simmons. The footage showed the incidents as reported by Ms. Dunlap, including youth A going toward the exit door and pulling on it, kicking on it and youth A trying to pull down on a ceiling vent. It also showed the two staff coming on the scene; one kid getting restrained as he ran from a room by Mr. Simmons; and Mr. Vaughn and Ms. Dunlap trying to restrain youth A; youth A struggling, the staff taking him to the wall, him sort of turning, him kicking, and then he and staff fall/go to the floor. Youth A being slammed or banged to the floor was not seen.

<b>APPLICABLE RULE</b>	
<b>R 400.4158</b>	<b>Discipline.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of corporal punishment inflicted in any manner.
<b>ANALYSIS:</b>	Though it is not clear how youth A received two scratches to the back of the neck, as indicated on the nurse's assessment, the evidence does not support the allegations as reported by youth A related to Mr. Vaugh slamming him to the floor and smashing his head to the floor twenty times. Youth A was struggling while staff were attempting to restraint him, he and Mr. Vaugh fell to the floor, causing him to hit his face and injury his eye.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4158</b>	<b>Discipline.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of corporal punishment inflicted in any manner. (c) Verbal abuse, ridicule or humiliation
<b>ANALYSIS:</b>	Youth A had a history of self-harming in an attempted to be sent out of the facility; and while being restrained, he struggled during the restraint; and when he was taken to the wall he banged his head to the wall.  The evidence does not support the allegations as reported by youth A related to Mr. Harper egging him on, calling him names, or smashing his head to a wall.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4112</b>	<b>Staff qualifications.</b>
	(1) A person with ongoing duties shall have both of the following: (a) Ability to perform duties of the position assigned. (b) Experience to perform the duties of the position assigned.

<b>ANALYSIS:</b>	The evidence does not support the allegations as reported by youth A related to Mr. Tyler or a staff grabbing his testicles doing a restraint. The evidence indicated it was youth A that would grab a staff in that area when he was restrained.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **ADDITIONAL ALLEGATION:**

During the course of the investigation it was revealed youth A, on or before 1/3/16 had received an injury to his chin requiring a visit to the emergency room, whereby he received stitches; and this incident was not reported to the Division of Child Welfare Licensing.

#### **INVESTIGATION**

Youth A alleged when he was slammed, during a restraint by Mr. Harper his eye opened up again, and his chin got injured; and blood was on the wall, and he went to the hospital and got stitches.

Ms. Dunlap reported there were two separate incidents. She, indicated the chin incident occurred a couple of days after the eye injury; that was indicated on 12/27/15.

Other staff interviewed, indicated, youth A had injured or reinjured his chin; and a 1/5/16 incident report with the nurse's assessment, indicated, youth A was bleeding from his wound on his chin that had stitches.

<b>APPLICABLE RULE</b>	
<b>R 400.4150</b>	<b>Incident reporting.</b>
	(1)Any incident resulting in serious injury of a resident or illness requiring inpatient hospitalization, shall be reported to the parent/guardian, responsible referring agency, and the licensing authority as soon as possible, but not more than 24 hours after the incident.
<b>ANALYSIS:</b>	The facility did not report youth A's chin injury, which resulted in an emergency room visit, and him getting stitches.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### **IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan, continuation of the of the facility's current licensing status is recommended.

**March 28, 2016**

_____ Lonia Perry Licensing Consultant	Date
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Approved By:

Linda Tansil Area Manager	Date April 4, 2016
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RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING

NICK LYON  
DIRECTOR

April 18, 2016

Julie Avant  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2016C0420020  
Detroit Capstone

Dear Ms. Avant:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

**FOR CWL ONLY**

Please note that violations of any licensing rules are also violations of the MSA and your contract.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2016C0420020
<b>Complaint Receipt Date:</b>	02/18/2016
<b>Investigation Initiation Date:</b>	02/18/2016
<b>Report Due Date:</b>	04/18/2016
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	1ST PROVISIONAL
<b>Effective Date:</b>	01/25/2016
<b>Expiration Date:</b>	07/24/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
There was sexual contact between two residents; one youth alleged he had sex with another youth and it was not consensual	No
Additional Findings	Yes

## III. METHODOLOGY

02/18/2016	Special Investigation Intake 2016C0420020
02/18/2016	Contact - Document Received From Quality Assurance Manager, T Henderson- She phone the consultant about this complaint,
02/18/2016	Contact - Document Received Email from Ms. Henderson, additional info
02/18/2016	Special Investigation Initiated - Telephone From Quality Assurance Manager T Henderson about this complaint, just prior to its receipt by DCWL
02/19/2016	Contact - Document Received Email from Ms. Henderson advising Youth M was taken into police custody, after they came out on 2/18/16
02/26/2016	Contact - Face to Face Interviewed Youth L, Therapists, Amanda Johnson, Amanda Danysh, Nurse, Diane Gaston, rec'd incident report, medical data, spoke with Quality Assurance Manager, T. Henderson
02/27/2016	Contact - Document Sent Email to Ms. Henderson requesting info
03/02/2016	Contact - Document Received Policy
04/13/2016	Contact - Document Sent Email RE contacts information non-receipt
04/14/2016	Contact- Face-to-Face Spoke with Quality manager, Stephanie Mitchell and Supervisor, Mr. Harden receive contact name for staff
04/14/2016	Contact- Telephone Call Made Spoke with Youth Specialist, Steven Harris
04/14/2016	Contact- Telephone Call Made



	Spoke with Youth Specialist, Otis Johnson
04/14/2016	Inspection Complete-Sub Compliance

### **ALLEGATION:**

There was sexual contact between two residents; one youth alleged he had sex with another youth and it was not consensual.

### **INVESTIGATION:**

Quality Assurance Manager, Taneisha Henderson, initially telephoned this consultant on February 18, 2016 to indicate one youth alleged he had sex with another youth and it was not consensual. When asked if the police was contacted, she indicated she was following up with the police; and she would provide more detail about the incident to this consultant. She emailed this consultant later and indicated, youth M admitted to the nursing staff that he sexually assaulted youth L, while they were in their rooms, during the midnight shift. Youth M reported the incident happened between the dates of February 1 and February 8 when he was not on 1:1 supervision. Youth M admitted that he penetrated youth L; and that youth L did not consent. She, indicated, the residents were separated for their safety and sexually transmitted disease testing was completed.

On February 19, 2016, Ms. Henderson, indicated, youth M was taken into custody the previous day, after the police came out to investigate.

Youth L (14) reported he has been at Detroit Behavioral Institute (DBI) for almost one year; and that he is in group C, in the Matrix program. He, indicated, he was from Bay County Michigan; and he was placed at DBI, due to his anger issues, but he was trying to get out of the placement. He, reported, he had been trying to talk with his Department worker. When this consultant explained why she was there to talk with him, youth L was resistant to talking. He, said, he didn't want to talk about it, that he had already told staff about it. When asked whether he felt safe in the facility, he stated, "I don't want to talk about it". When asked whether something happened to him, youth L stated, "I can't help you." When asked again if something happened to him, he, indicated, something bad happened. When asked whether that something bad was of a physical or sexual nature, youth L said, "Yes sexual". When asked whether the something bad of a sexual nature was something that he wanted to happen, youth L said, no. He, indicated, the incident happened in his room, maybe before midnight, but he wasn't sure of that. When asked who did the bad thing, youth L initially stated he couldn't tell who it was; then he indicated, it was his past roommate, youth M. When asked whether youth M said anything or asked him anything before the incident happened; youth M stated "he didn't ask me nothing he just did it". Youth L indicated "it" referred to youth M being sexually inappropriate with him; but youth L would not say actually what the sexually inappropriate act was. He, indicated, it happened twice; and that youth M told him to stop, to not say anything. Youth L, said, "He had me in a position where he would snap my neck"; and that youth M said, he would. When asked why he didn't tell any

staff this happened, youth L said, "Because you can get killed in here". When asked whether youth M threatened to do that, youth L said "what do you think?"

Therapist, Amanda Johnson, at the time of being interviewed, reported working at the facility for one month, and being youth L's therapist since she began. She spoke with youth L after the incident was discovered; and he was very guarded about the incident; but he told her that on two occasions, youth M was inappropriate with him. She, said, all youth L would say is that it was inappropriate touching; and youth M threatened to kill him. Youth L indicated the incidents happened on a Tuesday and Thursday, before 2/8/16. She said, youth L indicated there was another resident in the room, youth K; and youth K was asleep. When asked the size of youth M, Ms. Johnson indicated youth M is a tall stocky youth who looks older than his age.

Ms. Johnson, indicated, youth L is in a single room now; but he wants a roommate; that he feels as if he is being punished. When asked if it was true that there had been no contact with youth L's department worker, Ms. Johnson indicated it was true youth L had called his worker three times, and she (the department worker) hadn't pickup. Ms. Johnson, indicated, she has however, spoken with youth L's department worker about the incident, and youth L's behavior. Ms. Johnson, also, acknowledged knowing youth L wants out of the facility, but indicated youth L is a sophomore, he's now on relapse, and he has had four violations. She did not per see him being moved. She, indicated, after the incident was revealed, youth L went to the hospital, had blood tests, and physically, as far as she knew, the results were fine.

Ms. Johnson, indicated, she was not youth M's therapist, and she didn't talk with him about this incident, his therapist, Ms. Danysh did so.

Therapist, Amanda Danysh, reported, being youth M's therapist since 1/22/16. She said, she wasn't present when he disclosed the information to the nurse, but she, and Ms. Revyn spoke with youth M. She, said, youth M admitted it happened, that he sexually assaulted youth L, but he didn't go into detail. She, said, they asked youth M how could the incident happen and there be no noise, and youth M said youth L didn't scream or make a noise, and their roommate was asleep.

It is noteworthy this consultant had conducted another complaint pertaining to supervision surrounding youth M and his self-harming behaviors; and she recalled youth M had required 1:1 supervision, him being a large youth who appears older; and that he's placed from another state. Ms. Danysh affirmed that youth M was a youth out of Nebraska; and that he had been on 1:1 staffing due to self-harming behaviors. She, indicated, he was off 1:1 staffing between 2/2/16 and 2/8/16; and this (the incidents) occurred sometime on 2/2/16 and 2/4/16. When asked whether youth M had engaged in sexual acts with residents in past, Ms. indicated those were consensual, at least that what was alleged; and that/those incidents were believed to have occurred with another past roommate, youth C (Used for purpose of identification in this report). She, indicated, there was nothing known whereby he

was aggressive, that most of his problems were his self-harming behaviors. She, indicated, before youth M disclosed about this incident, they had put in a thirty day request for his removal; and he was past those thirty days.

Nurse, Diane Gaston, reported, youth M refused his 7:00PM medication, but then asked to speak with her about 9:00PM, so she thought he wanted his medication. She, said, he was in his room; a staff was in the door (he was on 1:1); and youth K was asleep. She, said, he apologized for how he acted at the med cart earlier, then he tried to whisper something to her, which she couldn't make out. She, said she asked youth K to leave the room; then youth M said he "raped" youth L, but he didn't do that other thing. She questioned him on what he meant, and he said, "You know, what people do when they have sex". And, when she said, ejaculate, youth M said, yes. She, said, she asked youth M whether anything else happened; and youth M said he forced youth L to perform oral sex on him. When she asked when the incident happened, youth M, said, it was one of those nights he was taken off 1:1 observations, a week or so ago. When she indicated that youth L hadn't said anything, youth M said, yes, that's because "I threatened to break his neck, if he did".

Nurse Gaston informed the supervisor, Mr. Harden and program coordinator, Ms. Sims of what youth M reported; and they asked her if she had spoken with youth L; and she let them know she had not, she wanted to apprise them first. She, said, when they spoke with youth L, she asked him, if youth M raped him; and youth L didn't want to talk about it; then he said, yes. She, said, youth L said youth M kept waking him up during the night by pulling the back of his head, and trying to put his( Youth M's) penis in his( Youth L's) mouth. She, said, youth M had said the oral sex happened; but youth L denied it, explaining his (Youth L's) dad said he should never let a man put their penis in his mouth. She, said, they asked youth L if youth M penetrated him by putting his penis in his rectum; and youth L said, yes. When they asked youth L how many time this had occurred, youth M, indicated, more than once, and less than five times. She, indicated, when they asked him why he didn't tell anyone, youth L, said, youth M threatened to kill him. When this consultant asked Nurse Gaston whether youth L reported youth M had said he would do something to his neck, youth L did not. She, said, youth L said "you guys know how big" youth M is; and that another reason he didn't tell was because he got raped at the last two facilities, and no one did anything; so he thought the same thing would happen here. She, said, youth L indicated that's why he didn't take showers, because he was afraid. She, said, he didn't say he was attack in the shower in the last placement, but she surmised he was indicating that. She, said, youth L was also refusing to take his medication, and he indicated he wasn't taking it, because he didn't want to go to sleep.

Nurse Gaston affirmed youth L's physical examination and testing; she indicated he was to return to the hospital on 2/24/16, but the appointment was missed, due to a transportation log issue; and it had been rescheduled. When asked why was youth L placed in a room with youth M and youth K, especially given youth M's physical size,

Ms. Gaston was not sure; but she reported believing the room assignments were done by supervisors, and that kids were placed in rooms together due to their age group.

The CEO Julie Avant was asked the same question, as to why youth L was placed with youth M; and she reported basically report the same with respect to rooming based on age group; and she deferred to Ms. Henderson to elaborate more to this consultant.

When Ms. Henderson, was asked why youth M and youth L were roommates, she indicated the facility looks at age of the youth not physical status; and youth M and youth L were in the same age group, that being within a two year age range. When asked didn't youth M have past sexual acting out issues that should have been looked at or taken into consideration, Ms. Henderson indicated youth M didn't have any assaultive or aggressive issues; his problems were related to self-harming. She indicated, the one past sexual incident or issue youth M had was with youth C; and it was believed to have been mutual. She, said, youth L wasn't a kid that identified as being homosexual, but youth M was.

Youth K (16) reported being past roommates with youth M and youth L. He, indicated, they all were separated, because "there was an incident, but I don't know anything about it, I must have been sleeping when it happened". He, said, he never observed anything inappropriate between youth M and youth L, but that he knew staff said youth M raped youth L. He, reported, knowing youth L went to the hospital, and youth M was no longer at the facility. He denied hearing or seeing any inappropriate actions between youth M and youth L; he stated "I didn't see or hear anything, I'm like a really heavy sleeper." When asked how youth M and youth L got along, youth K said, "They got along a little bit alright." That sometimes youth M would tease youth L; and at times youth L teased youth M. He, said, the two would fake play, wrestle, and horseplay a lot. When asked what staff did when that happened, youth K indicated staff wouldn't see it, and if they did, they would tell them to stop. When asked if youth L ever said anything about being concerned, or afraid around youth M, youth K indicated, youth M was "way bigger than" youth L, but youth L never acted afraid of youth M.

Youth M was not interviewed, he was no longer at the facility, but his written statement was reviewed. That statement, indicated, "I don't remember the day, but it was a night that I was off 1on 1. On midnight shift I (Youth M's full name) sexually assaulted resident (youth L's full name), It was oral, and anal. I then threatened to kill him in his sleep (snap his neck). He was crying on 2-17-16, because I said I would snap his neck. Resident (youth K's first name) was asleep." The statement was signed by youth M.

Youth Specialist, Steven Harris, staff reported as doing rounds on the afternoon shift; and Youth Specialist, Otis Johnson staff reported as doing rounds on the midnight shift, on the times it was estimated the incidents may have happened, both

reported not recalling any red flags or anything out of the normal back in February. Both indicated they conducted rounds as required, and when they checked the room nothing unusual was recalled. Both recalled hearing about the incident after the fact; and neither said they were interviewed by facility staff about the matter.

Mr. Harris reported speaking with youth L the day after youth M left the facility. He, said, youth L told him youth M grabbed him around the neck when he was sleeping, and told him not to say anything or he(youth M) would snap his neck. He, said, youth L said youth M got on top of him and raped him; and that it happened on the midnight shift. Mr. Harris, said, youth L indicated, he didn't tell, because he was afraid. Mr. Harris reported, he never observed anything inappropriate, when he "sat on them" meaning when he supervised them/ did 1:1 supervision of youth M.

Mr. Harris as did Mr. Johnson reported providing 1:1 staffing to youth M, where they sat in the room near him or his bed, but neither knew why youth M was taken off 1:1 staffing. Mr. Harris indicated he was providing the 1:1 supervision one day, and then he was told the youth was no longer on such, and to come off the 1:1 supervision; and then, supposedly, the incident happened two to three days after that.

Mr. Johnson, indicated youth M was on and off 1:1 staffing, that youth M would get taken off, then he was placed back on the next day or so, and so it was hard to pin point when he was off of it. Both he and Mr. Harris, indicated, when they checked residents' room they did so every ten minutes, by turning on the light and looking inside. Mr. Harris, indicated, he would popped the door, and peek in to assert all was ok; and Mr. Johnson, indicated, they would only open the door and go in, if there was something heard or noticed out of the norm. He, indicated, normally on the midnight shift the residents are always asleep.

### **Reviewed:**

#### Incident reports:

- One dated 2/17/16 for 9:20 PM, which indicated, youth M requested to see the nurse, and what he reported. That he alleged that he raped his roommate, forced him to perform oral sex, and also alleged he threaten to break his roommate's neck.
- One dated 2/17/16 for 9:30PM of youth L's interview by nurse Gaston, Mr. Harden and Ms. Sims, which basically indicated what nurse Gaston reported when interviewed.
- One dated 2/18/16 of the nurse's notification of the incident to the facility's doctor, Dr. Bryant; and his advisement to send youth L to the hospital for further evaluation.

#### File document review for youth M that showed:

- He was admitted into the facility on 3/6/15; his status/detainment was indicated, as "Destruction of Property". He was placed at the facility from Elkhorn Nebraska; and he was discharged from the facility 2/18/16.

- A 3/12/15 Initial Risk Assessment (Suicide, Aggression, Sexual Assault and /or Vulnerability), which indicated, when he was interviewed, he reported he had never physically or sexually assaulted anyone, nor had anyone ever touched him in a way that made him uncomfortable. He was assessed to have a suicide risk level as moderate; level of violence risk as low, with property damage indicated as another identified risk. The assessment concluded youth M was at risk “of suicidality”. Sexual aggression was not indicated at that time, though special housing was recommended.
- Youth M’s diagnoses, per an updated psychiatric evaluation dated, 9/15/15, included, Conduct Disorder, Disruptive Mood Dysregulation Disorder, and Borderline Personality Disorder. His risk factors were indicated as “his Borderline Personality Disorder and his continued aggressive behaviors”. The disposition and recommendation included continued medication changes to help youth M’s mood liability, adding Depakote 500mg Pbid to treat his significant aggressive, and consider switching his Lexapro to Prozac. His insight and judgment was indicated as poor at the time, and his motivation for treatment limited. Discharge planning and recommendation indicated, the youth may benefit by a higher level of care in an inpatient psychiatric setting; and his prognosis appeared guarded.
- He was 6’1”, and weighed 275 pounds.
- He was on and off 1:1 supervision due to suicidal ideations, self-harming behaviors.

File documentation review for youth L that showed:

- He was admitted into the facility on 9/16/15; his status/detainment was indicated as “Exception”. He is a permanent state ward, from Bay County Michigan.
- A placement exception request (PER) for placement in the facility was granted for ninety days from 9/16/15 through 12/15/15. An updated PER was not on file, at the time of the file review. Ms. Henderson indicated the exception request was the responsibility of youth L’s department worker.
- A 9/17/15 Initial Risk Assessment (Suicide, Aggression, Sexual Assault and /or Vulnerability), which indicated, when youth L was interviewed he reported he had physically assaulted someone, and that he had been touched in a way that made him uncomfortable. The risk assessment, indicated, youth L did not want to share the information, but noted children services were involved and that was when he was four. Youth L’s risk assessment’s observation section indicated, “He is smaller in stature for his age”. His suicide, aggression/violence risk was assessed as low; and he was not assessed to be at risk for serious physical assault, sexual aggression, or sexual victimization; and no special housing was recommended.
- Youth L, per his psychiatric evaluation dated 10/2/15, indicated, youth L has a long history of abuse, neglect, aggressive behavior, and multiple foster home placements; and psychiatric and psychological placements. His diagnoses included, Bipolar Disorder; Conduct Disorder, Childhood Onset, with limited Motions; Post Traumatic Stress Disorder, Chronic; Sexual Abuse of a Child

(Victim); Physical Abuse of a Child (Victim); Intermittent Explosive Disorder; R/O Psychotic Disorder, NOIS. Youth L admitted to a history of auditory and visual hallucinations; and his cognitive status could not be assessed at that time, due to his very poor compliance, at that time. His insight and judgement appeared very poor; as did his motivation for treatment. His prognosis appeared guarded at that time.

- He is 5'2", and weighs 102 pounds.

Facility's Room Assignment and Use policy that showed:

- When assigning room assignments the following should be considered:
  - Level of emotional and cognitive development;
    - Physical size and stature.
    - Mental illness or mental disabilities.
  - Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions or separation from certain other residents.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(3) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS:</b>	<p>There is insufficient evidence to conclude, a lack direct care and supervision.</p> <p>Staff indicated, youth M was on and off 1:1 staffing due primarily to his self-harming behaviors; and that at the times he was taken off 1:1 staffing it was due to him showing progress for a period of time. On 2/17/16, Youth M self-disclosed that he sexually assaulted youth L; and that it occurred during a time he was not on 1:1 staffing. Had he not disclosed, it is unknown, when or if his victimization of youth L would have surfaced; and an exact date and time of the assaults cannot definitively be determined. Though it is surmised the assaults may have occurred on 2/2/16 and 2/4/16 on the night or midnight shift, because youth M was off of 1:1 staffing from 2/2/16 to 2/10/16; and youth L indicated the assault days were a Tuesday and Thursday before 2/8/16. The staff persons identified as conducting rounds on the two speculated dates, shifts, reported recalling no indicated or observed concerns, or red flags back for that time; and each staff indicated rounds were conducted at ten minute intervals with eye-on checks of the residents via the residents' room window or opened door.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4109</b>	<b>Program statement.</b>
	(1)An institution shall have and follow a current written program statement which specifically addresses all of the following: (c)Policies and procedures pertaining to admission, care, safety, and supervision, methods for addressing residents' needs, implementation of treatment plans , and discharge of residents
<b>ANALYSIS:</b>	<p>Youth L a youth of very small built and status(5'2", 102 pounds), for is age, and a past victim of physical and sexual abuse was roomed with youth M who more than doubled his size, at 265 pounds, and who stood at 6'1". And though both he and youth M had a history of mental health diagnoses, concerns, and aggressive behaviors; and youth M was not, at the time of admission in March 2015, assessed as sexually aggressive; youth M had a subsequent sexual incident with a roommate prior to being placed in a room with youth L that resulted in the residents' room separation. And, youth M's risk factor as of his 9/15/15 updated psychiatric evaluation listed his risk factors as his Borderline Personality Disorder, and his continued aggressive behaviors; and it was recommended that youth M would benefit from a higher level of care in an inpatient psychiatric setting; as his prognosis appeared guarded.</p> <p>The facility did not adhere to its policy that indicated it should consider the youth's physical size and stature, mental illness or mental disabilities, and other specifics information in room assignments. And not fully doing such conceivably may have contributed to youth M's sexual assault of youth L</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>



#### **IV. RECOMMENDATION**

Upon a receipt of an acceptable corrective action plan, continuation of the facility current licensing status is recommended.

**April 14, 2016**

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Lonia Perry	Date
Licensing Consultant	

Approved By:

**April 18, 2016**

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Linda Tansil	Date
Area Manager	



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DEPARTMENT OF CHILD WELFARE LICENSING

NICK LYON  
DIRECTOR

June 2, 2016

Julie Avant  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2016C0420026  
Detroit Capstone

Dear Ms. Avant:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2016C0420026
<b>Complaint Receipt Date:</b>	03/31/2016
<b>Investigation Initiation Date:</b>	03/31/2016
<b>Report Due Date:</b>	05/30/2016
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	1ST PROVISIONAL
<b>Effective Date:</b>	01/25/2016
<b>Expiration Date:</b>	07/24/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
While youth A was a resident at the facility, she was sexually assaulted by a Nurse T; and Nurse T also sexually perpetrated youth B, who was also a resident at Capstone. After the incident with youth B, Nurse T was let go from the facility. Youth A and Youth B are now residents at Muskegon River Youth Home.	No
Additional Findings	No

## III. METHODOLOGY

03/31/2016	Special Investigation Intake 2016C0420026
03/31/2016	Special Investigation Initiated - Telephone Spoke with Quality Assurance Manager, Taneisha Henderson RE Complaint, requested information
03/31/2016	Contact - Telephone call made Spoke with DHHS Worker
03/31/2016	Contact - Telephone call made Left message for Ms. Henderson RE other youth named in complaint, and information needed
03/31/2016	Contact - Telephone call made Spoke with DHHS worker RE other youth named in complaint; need for interview of both youths
03/31/2016	Contact - Document Received Emails received from Ms. Henderson
04/14/2016	Contact - Face to Face Spoke with residents, obtained contact information for prior staff
04/19/2016	Contact - Document Received Email from DHHS Worker, of Youth A & Youth B's interviews by DHHS Worker 2
04/19/2016	Contact - Document Received Contact email from DHHS Worker
04/26/2016	Contact - Telephone call made To DHHS Worker

04/27/2016	Contact - Telephone call made left Message for Nurse T1
04/27/2016	Contact - Telephone call made Attempted contact with Nurse T2- voicemail full
04/27/2016	Contact - Telephone call made Spoke with DHHS Worker
04/29/2016	Contact - Document Received Email from and to DHHS Worker RE Pending Contact with Nurse T2
05/03/2016	Contact - Telephone call made Returned DHHS Worker Phone message, spoke with her
05/03/2016	Contact - Face to Face Consultant and DHHS Worker spoke with Nurse T2
05/03/2016	Contact - Telephone call made Calls by DHHS Worker and this consultant, Interviewed nurse LySandrer Walker and Youth Specialist, DelShanique Beavers separately interviewed
05/06/2016	Special Investigation-Full Compliance

#### **ALLEGATION:**

While youth A was a resident at the facility, she was sexually assaulted by a Nurse T; and Nurse T also sexually perpetrated youth B, who was also a resident at Capstone. After the incident with youth B, Nurse T was let go from the facility. Youth A and youth B are now residents at Muskegon River Youth Home.

#### **INVESTIGATION:**

Quality Assurance, Manager, Taneisha Henderson, indicated youth A was admitted to the facility on 2/4/15, and discharged 11/23/15; and youth B was admitted to the facility on 2/26/15. Youth B was discharged to the agency's Apex program 4/22/15; and later discharged from Apex on 6/11/15. Ms. Henderson, indicated, there were no past complains or grievances of a sexual assault nature for youth B, and other than the complaint investigated, by this consultant, a few months back, related to youth A, there had not been any for youth A.

Ms. Henderson reported the facility had two different Nurse Ts to work at the facility; both of whom are no longer employed there. She, indicated one person had resigned, but she was not sure of that date until checking with the facility's human resource department. She, indicated, Nurse T1 was employed with the facility from 6/1/15 to 6/5/15; and he resigned due to family reasons. She, indicated, Nurse T2

was employed from 8/8/14 to 6/3/15; at which time he went contingent, and never returned to complete a shift.

Youth A, youth B and youth C were interviewed by a courteous worker, DHHS Worker 2 on 4/1/16 utilizing Michigan Forensic Interviewing Protocol; and that worker also spoke with the Director of Muskegon River Youth Home, Dawn Kruithoff, prior to interviewing the youths. DHHS Worker 2's interviews, as it relates this allegation are indicated below. The youths' names are coded.

DHHS Worker 2 indicated the Muskegon River Youth Home's Director, "Dawn", stated, Detective Keathley from the Osceola County Sheriff's Department and Kathy Fiorletta from licensing attempted to interview youth A last year about the same allegations against DBI (Detroit Behavioral Institute) and youth A refused to talk. DHHS Worker 2, indicated, the Muskegon River Youth Home director, indicated this is youth A's second placement at the facility, and this time around youth A is doing much better. Dawn stated she is still very impulsive and attention seeking. And Dawn stated youth B is also very assaultive.

DHHS Worker 2's interview, indicated, Dawn was not aware of any concerns reported by youth B about her stay at DBI. That Dawn stated youth A and youth B would have had time to talk with each other during the youth's short time at the GTU (girls' treatment unit). That youth A was placed back at Muskegon River on 2/5/16 and youth B was placed on 7/15/2015.

DHHS Worker 2 indicated after being introduced to youth A, youth A, immediately stated, "What do you want?" and youth A was advised that the worker wanted to talk to her about her time at DBI; and youth A stated, "I already told them I am not talking about it." Youth A was asked who she told that to, and she repeated "them".

DHHS Worker 2, indicated, youth A was able to distinguish the difference between a truth and a lie, and agreed to tell the truth. DHHS Worker 2, indicated, when the other forensic interviewing rules were addressed with youth A, she nodded her head indicating she would follow them. Youth A was asked if there was anything she would like to share about her time at DBI. Youth A stated she would talk about some things, but not everything. Youth A was asked to share what she was willing. Youth A reported that they were "abusive". Youth A was asked more about this. She stated that the staff would take residents on "elevator rides" and hit them in the head with walkie talkies. Youth A stated they would do "illegal restraints" by twisting the arm behind the back and pushing it to their head. Youth A stated they once broke her friend's arm. Youth A was asked about which staff were doing these things. Youth A stated she remembered who, but refused to tell DHHS Worker 2. Youth A reported that Youth C, who is currently placed at Muskegon River Youth Home with her, also had those things happen to her.

Youth A stated she met with children services "every week" while she was at DBI and nothing was ever done about what they were doing, and she did not believe

anything would be done this time around. Youth A reported when she talked to children services, the staff would lecture them about snitching.

Youth A refused to tell DHHS Worker 2 the information that she was not going to talk about. Youth A was asked about which topic was being avoided, so the worker knew not to talk about it; and youth A refused to talk or make eye contact. Youth A was asked if the topic was related to someone making her uncomfortable; and she said "yes". Youth A was asked if she knew a Nurse T that worked at DBI; and youth A stated Nurse T was a nurse there, and he would see them when they were injured or to delivered medications. Youth A reported she once had to see him when she cut open her leg from the residents cutting each other. Youth A stated she could see "white meat" and felt she needed stitches, but Nurse T would not allow her to go to the hospital. Youth A stated she also saw him three times a day whenever he worked, because he passed out medications. Youth A was asked if there were ever times she was alone with Nurse T. She, stated, she was alone with him when she would get nose bleeds. Youth A was asked several more clarifying questions, and refused to speak with DHHS Worker 2.

Youth B was interviewed next by DHHS Worker 2; and youth B was asked about her experience at DBI. Youth B stated that things were "rocky" and ultimately she ran away from there. Youth B, stated, that they would place residents in restraints and had broken a friend's arm. Youth B stated she personally had her shoulder dislocated from a restraint. Youth B reported her only concern is the restraints they are doing on kids. Youth B was asked if there was a staff by the name of Nurse T. Youth B reported he was a nurse. His job was to "check out people" and give medications. Youth B stated she met him when she was first placed there, and he was "nice". Youth B denied she ever had a bad encounter with Nurse T. He never made her feel uncomfortable.

Per DHHS Worker 2's interview with youth C, youth C denied any sexually inappropriate touching towards her at the DBI.

Per the information alleged by youth A, pertaining to youth C, and DHHS Worker 2's interview with youth C that information, therein, came in the form of a complaint to the Division of Child Welfare Licensing (DCWL); and that matter, and what was indicated with DHHS Worker 2 is addressed in special investigation 2016C0420027.

It is noteworthy that incidents youth A indicated to DHHS Worker 2 pertaining to mistreatment by staff at DBI, and staff taking kids on elevator rides, and hitting them with walkie talkies were investigations pertaining to youth A; and were investigated via special investigation 2016C0420002, and 2016C0420005. Additionally, special investigation 2015C0420019 investigated the allegation youth A and youth B spoke of pertaining to a youth's arm being broken. It is also notable that the allegation addressed in this report was previously investigated via special investigation 2016C0420018; but findings were inconclusive due to lack of evidence, and no named alleged perpetrator.

Youth D, youth E, youth F and youth G were interviewed related to another complaint, and also in general related to staff interaction with residents. Youth D reported hearing about an issue involving youth F, and her reportedly being fingered by a staff; and that youth G was in the group room when it happened.

Youth E, indicated, staff treat residents “with dignity and respect if you treat them that way”. She, said, she had never been restrained, but she had seen other residents restrained, and she was not sure what was consider an improper restraint. She, said staff worked in a professional manner with residents; and as far as, she knew, staff were not stepping over professional boundaries. When asked whether she had ever heard of any resident saying a staff had been inappropriate with a resident, youth E indicated youth F told her a staff, whom youth F did not name, “fingered her”; but “ I don’t think it’s true”. Youth E, said, youth F told her that back in March 2016; and that youth E lies about anything.

Youth F reported feeling safe in the facility, but indicated staff can be irritating, due to her believing staff gossips about her. When asked whether she was aware of any staff being inappropriate with a resident in a sexual way, youth F indicated, “They wouldn’t do that”. She indicated staff looks at her as a daughter. When asked whether any staff had been inappropriate with her, youth F stated, no.

Youth G reported feeling treated with dignity and respect with all staff; except, Ms. Brown; because they don’t get along, due to Ms. Brown wanting to write her up for violations, and her not being listened to. Youth G was not aware of any staff being inappropriate with a resident in a sexual manner; nor had she heard of any resident saying a staff had been sexually inappropriate with a resident.

An attempt was made by this consultant to contact, Nurse T1, but that was unsuccessful. The DHHS Worker was able to connect to Nurse T1 via telephone on 4/19/16; and she reported the following: Nurse T1 “stated, that he went through orientation but never worked a shift on the floor at all, or had any contact with any residents. He, stated, that just going through orientation was enough for him to realize this was not the job for him, so he never reported to work. He declined to meet with me regarding these allegations as he cannot take time off of work.”

Nurse T2, acknowledged being employed at DBI. He reported employment at DBI from sometime in 2014 until about May of 2015, when the facility terminated him, after he tried to go contingent; and some confusion and disagreement over that; and him not calling in. He recalled youth A, but not youth B; and he denied the allegations. He, indicated, he never really dealt with the female residents on any regular basis; and when he did, a female staff was present with him. He, said, he dealt with the residents during medication passes, and after restraints; and that nothing ever happened with youth A or any resident. He, said, he usually checked the kids out at their door, and never whereby he had to go under their clothing. He, stated he only checked youth A out after a restraint; and she never had to take off



her clothing; and nor was he in the room along with her or any resident. He, said, he worked the afternoon shift, and some mornings; and on the afternoon shift, Ms. Beavers, who was a supervisor at the facility, was with him. He, said, he had also worked with Nurse, Walker and she could speak to his character. He, reported, no prior children services or DBI investigations; he recalled there being another Nurse T that worked at DBI after him, but he was not sure whether that nurse was male or female.

Nurse, Lysander Walker reported, Nurse T2, and she were co-workers; he worked at the DBI-Main facility, and she was at the DBI- Apex facility. She, reported, no concerns with Nurse T2, or his interactions with residents; and indicated; “He was a really great nurse, and they hated to lose him”. She, indicated, Nurse T2 would have followed protocol when examining youth A , youth B, or any resident, which would be to do body charts, medication passes, and assessing the resident after a restraint. She, said, they don’t look at the resident’s private parts; and a nurse would not examine a resident of the opposite sex of them (the nurse) without another staff of the resident’s gender being present.

Youth Specialist, DelShanique Beavers, reported, she had worked with Nurse T2 numerous occasions during afternoon shifts as DBI-Main. She could not recall a time he examined youth A or youth B alone. She, indicated, per facility policy, she, as the supervisor, or another female staff would accompany the nurse to the area the nurse would assess the resident, and it would be in an open area, not alone in the resident’s room. Ms. Beavers had no concerns of Nurse T2 being sexually inappropriate with any resident.

<b>APPLICABLE RULE</b>	
<b>R 400.4112</b>	<b>Staff qualifications.</b>
	(1) A person with ongoing duties shall have both of the following: (a) Ability to perform duties of the position assigned. (b) Experience to perform the duties of the position assigned.
<b>ANALYSIS:</b>	The evidence does not support the allegations of sexually assault or inappropriateness by Nurse T.  Nurse T1, was only employed by the facility for five days in June 2015, and never worked with residents. Nurse T2 was employed from August 2014 to June 2015; and there is insufficient evidence to support the allegations.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **IV. RECOMMENDATION**

Continuation of the facility’s current licensing status is recommended.

May 27, 2016

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Lonla Perry Licensing Consultant	Date
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Approved By:

**June 2, 2016**

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Linda Tansil Area Manager	Date
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RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
LANSING

NICK LYON  
DIRECTOR

June 2, 2016

Julie Avant  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2016C0420027  
Detroit Capstone

Dear Ms. Avant:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

**FOR CWL ONLY**

Please note that violations of any licensing rules are also violations of the MSA and your contract.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2016C0420027
<b>Complaint Receipt Date:</b>	04/05/2016
<b>Investigation Initiation Date:</b>	04/06/2016
<b>Report Due Date:</b>	06/04/2016
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	1ST PROVISIONAL
<b>Effective Date:</b>	01/25/2016
<b>Expiration Date:</b>	07/24/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
There was maltreatment of a past resident, youth A, by past or current staff at the facility. She received 18 stitches from staff, Mr. O, Ms. J and Mr. H hitting her head on a concrete bed frame.	No
Mr. S writes notes to the female residents, gives them his phone number and address, saying they can contact him, he will help them with money if they complete sexual tasks for him.	No
When youths are restrained they are placed in the elevator which has no camera, they are hit and slammed. Youth A and youth B were placed in the elevator, and hit in the head with a walkie talkie. Mr. S was one of the staff who participated in this.	No
Youth A witnessed a staff named Mr. D who worked at the facility from 2013-2014 fingering a female resident in the group room behind the camera.	No
The facility's food is gross, kids do not get enough, and a prior resident loss lots of weight while placed there; was given spoil food, and once a fly was in a resident's food.	No
The entire facility is infested with cockroaches; and in February there were roaches crawling out of a water fountain.	No
The facility is dirty.	Yes
Additional Findings	No

## III. METHODOLOGY

04/05/2016	Special Investigation Intake 2016C0420027
04/06/2016	Special Investigation Initiated - Telephone Spoke with DHHS Worker
04/14/2016	Contact - Face to Face Interviewed residents and staff, rec'd documents, toured facility
04/14/2016	Contact - Telephone call made Spoke Staff 1
04/14/2016	Contact - Telephone call made Spoke with Staff 2
04/19/2016	Contact - Document Received Emails from and to the DHHS Worker
04/19/2016	Contact - Document Received Email from the DHHS Worker of DHHS Worker 2's interviews of

	youths
04/26/2016	Comment- Reviewed prior complaints for the facility
04/26/2016	Contact - Telephone call made To DHHS Worker
04/27/2016	Contact - Telephone call made Attempted contact with Mr. Oldham- number disconnected
04/27/2016	Contact - Telephone call made Spoke with DHHS Worker
04/28/2016	Contact - Document Sent Provided past investigated report on youth to DHHS Worker
04/29/2016	Contact - Document Received Email from DHHS Worker, she located the children services report
05/02/2016	Contact - Telephone call made Case conference with DHHS Worker and her supervisor
05/02/2016	Inspection Completed-BCAL Sub. Compliance

#### **ALLEGATION:**

There was maltreatment of a past resident, youth A, by past or current staff at the facility. She received 18 stitches from staff, Mr. O, Ms. J and Mr. H hitting her head on a concrete bed frame.

Mr. S writes notes to the female residents, gives them his phone number and address, saying they can contact him, he will help them with money if they complete sexual tasks for him.

When youths are restrained they are placed in the elevator which has no camera, they are hit and slammed. Youth A and youth B were placed in the elevator and hit in the head with a walkie talkie. Mr. S was one of the staff who participated in this.

Youth A witnessed a staff named Mr. D who worked at the facility from 2013-2014 fingering a female resident in the group room behind the camera.

#### **INVESTIGATION:**

Youth A, youth B and youth C were interviewed by a courteous worker, DHHS Worker 2 on 4/1/16 utilizing Michigan Forensic Interviewing Protocol; and that worker also spoke with the Director of Muskegon River Youth Home, Dawn Kruithoff, prior to

interviewing the youths. DHHS Worker 2's interviews, as it relates to these allegations are indicated below. The youths' names are coded.

Youth B was asked if there was anything she would like to share about her time at DBI. Youth B stated she would talk about some things, but not everything. Youth B was asked to share what she was willing. Youth B reported that they were "abusive". Youth B was asked more about this. She, stated, that the staff would take residents on "elevator rides" and hit them in the head with walkie talkies. Youth B, stated, they would do "illegal restraints" by twisting the arm behind the back and pushing it to their head. Youth B, stated, they once broke her friend's arm. Youth B was asked about which staff were doing these things. Youth B, stated, she remembered who, but she refused to tell DHHS Worker 2.

Youth B reported that youth A, who is currently placed at Muskegon River Youth Home with her also had those things happen to her. Youth B, stated, youth A's head was slammed into a wall and she has a large scar from this.

Youth C was asked about her experience at DBI. Youth C stated, that things were "rocky" and ultimately she ran away from there. Youth C, stated, that they would place residents in restraints and had broken a friend's arm. Youth C stated she personally had her shoulder dislocated from a restraint. Youth C reported her only concern is the restraints they are doing on kids.

Per DHHS Worker 2's interview with youth A, youth A stated she was at DBI two times; and she had to talk to children services one time while at DBI in about 2013. Youth A reported she was placed at Muskegon River Youth Home (MRYH) about one to two months ago. Youth A presented adequately dressed and free of any observable bruises or other current marks. Youth A did have a scar approximately 3 inches in length that ran from the top of her left eyebrow down across her nose to the side of her right eye. Youth A was asked how things were while she was placed at DBI. She explained that she got the scar on her eye from DBI in the fall of 2013. Youth A stated she was in an argument with another female resident; and staff restrained her, and brought her into her room. Youth A, stated, that they pulled her arm behind her back and up to her head. Youth A stated the beds ran foot to head. Youth A stated, one of the bed mattress was missing, and it was just the cement bed frame, and they pushed her head into it, and her face hit the rim of the bed frame, causing blood to gush out. Youth A, stated, Mr. O, Ms. J, and Mr. H were the staff that did this. She, stated, they no longer work there, and she believes some of them may have been fired as a result of this incident. Youth A, stated, that her eye was swollen shut, cheek bone fractured, and had some head trauma. Youth A reported that after her face was hit on the bed frame, they wrapped her in the green suicide gown and it was not until a nurse came in and told them that she needed medical attention that they let her go. Youth A stated she believes that she talked to children services, and they took pictures of it.



Per DHHS Worker 2's interview youth A, youth A reported that the staff at DBI would give the residents things to cut themselves with. Youth A reported if you told the staff you were suicidal or wanted to harm yourself, they would hand you sharp objects or give you a bottle of shampoo and tell you to drink it. Youth A reported staff have also provided ropes for residents to hang themselves. Youth A denied she could remember which staff participated in these things.

DHHS Worker 2's interview continued and indicated, youth A stated that the elevator does not have a camera, and they (staff) would place residents in the elevator during restraints. She, stated, they would use the elevator to transport to the BMR (behavioral management room) or the rooms. She, stated, they would hit them in the head with walkie talkies; and would slam them into each of the four walls within the elevator. Youth A could not remember a specific time, but stated it happened on multiple occasions. She, stated, that her head would have bumps from being hit. She does not have any current injuries from this. Youth A reported Mr. S was one of the staff that participated in this, along with "most of the supervisors".

Youth A denied any sexually inappropriate touching towards her at the DBI. She did disclose that a staff was writing notes to residents, where he provided his name and number to her; and told her that she could earn money by doing "sexual stuff" when she got out of DBI. Youth A refused to provide this staff's name. She, stated nothing ever happens to DBI, and it would not help for her to say a name now. Youth A stated she lives in the Detroit area, and she is afraid someone will come after her if she discloses the name. Youth A was advised by DHHS Worker 2 that this worker and any other workers cannot do anything about what has happened or may be happening if she does not provide a name of who is doing these things. Youth A stated she would tell the worker what happened like it happened to someone else. Youth A stated that Mr. S wrote a letter to a female resident providing his phone number and address, and said she could make money or he would give her a ride somewhere if she wanted to make some extra money. Youth A stated that this girl was her roommate in the end of 2014, but she refused to provide a name. Youth A stated that Mr. S mostly works the boys unit, until someone needs a break or he is on float. Youth A would provide no further details.

Per DHHS Worker 2' interview with youth A, youth A stated she witnessed a Mr. D who worked there(DBI) between 2013 and 2014 "finger" another resident behind the camera in the group room while other residents were watching a movie. Youth A did not know if anyone else witnessed this, and did not know the resident's name.

Quality Assurance Manager, Taneisha Henderson recalled the incident of youth A's injury and her requiring stitches; and the investigation by this consultant, and a DHHS Worker. She located the facility's copy of that special investigation.

Ms. Henderson indicated, no residents had filed grievances related to issues in this complaint. In terms of past named staff she provided the following related to their

termination dates; Mr. O's employment terminated with the facility 2/21/14, Mr. H's 10/25/13; and Mr. D's 9/11/13.

Youth D, youth E, youth F and youth G were interviewed related to another complaint, and also in general related to staff interaction with residents.

Youth D, reported, feeling staff treat residents horribly, and that they don't care about the kids. She, said, once Mr. S said he was going to break her arm; and another staff had pulled her arms high up behind her back when she restrained her. She, said, once she was also slammed to the floor and, dragged to the BMR, when she wasn't resisting, but she did not recall when that was, nor reported what staff that was.

Youth D, reported, hearing about an issue involving youth F, and her reportedly telling someone she had a sexual relationship with a staff. Youth D said youth F said it was a Mr. T; and the youth E knows that secret; that youth F said they were in the group room talking and the staff touched her thigh and the staff fingered, while they acted like they were playing cards. Youth D, said, youth G was in the group room when it happened.

When asked whether she had ever heard of anything sexual being mentioned about any staff, youth D stated Mr. S. She, said, youth F said, Mr. S talked about his strip club; and wrote and hinted he wanted her to work at his club. Youth D had not heard about this staff or another staff writing letters to residents; but she indicated she heard that Mr. S is the one who talks with kids in a sexual way.

Youth E, indicated, staff treat residents "with dignity and respect if you treat them that way". She, said, she has never been restrained, but she had seen other residents restrained, and she was not sure what was considered a proper restraint. She, said staff worked in a professional manner with residents; and as far as, she knew, staff were not stepping over professional boundaries. When asked whether she had ever heard of any resident saying a staff had being inappropriate with a resident, youth E indicated youth F told her a staff, whom youth F did not name, "fingered her"; but " I don't think it's true". Youth E, said youth F told her that back in March 2016; and that youth E lies about anything.

Youth F reported feeling safe in the facility, but indicated staff can be irritating, due to her believing staff gossips about her. When asked whether she was aware of any staff being inappropriate with a resident in a sexual way, youth F indicated, "They wouldn't do that". She, indicated, staff looks at her as a daughter. When asked whether any staff had been inappropriate with her, youth F indicated, no.

When asked whether she had heard of staff taking kids on elevator rides, youth F indicated she had heard about dirty restraints on the elevator, but nothing like that had happened to her. When asked whether she had heard anything about staff writing notes to residents offering to help them get a job when they get out, youth F

indicated, yes. Youth F, said a female staff had offered to help a female resident who had a baby to get a job when they got out. Youth F had not heard any male staff offering to do such a thing.

Youth G reported feeling treated with dignity and respect with all staff; except, Ms. Brown; because they don't get along, due to Ms. Brown wanting to write her up for violations, and her not being listened to. Youth G was not aware of any staff telling a resident to hurt themselves, or giving residents things to hurt themselves. She, indicated, when kids are self-harming staff will restrain them and take the object from them. She, indicated, once a female resident tried to kill herself by tying a socks together, and that resident was put in the observation room.

Youth G was not aware of any staff being inappropriate with a resident in a sexual manner; nor had she heard of any resident saying a staff had been sexually inappropriate with them. Nor was youth G aware of any staff writing notes to girls, or giving them their address and phone number.

Youth Specialist, Mr. S reported employment with the facility since August 2014. He, said, he used to work strictly with the Horizon group, but he had been a Floater as of 2/16. He, recalled, youth A; but did not recall any an incident with her in the elevator. When the DHHS worker read the allegations to him, he indicated not recalling anything like that. He denied the allegations. He said he had never written any letters to residents, nor had he given them his name and or address and telephone number to contact him. When the allegation was read about him offering to give help to a resident after release, for sexual favors, he asked if we had the correct person; and denied doing such.

Mr. S denied any staff telling kids to commit suicide or staff giving kids shampoo to drink, or of any staff giving kids objects to cut or harm themselves.

Staff 1, indicated, some staff go by the rules, some just try to get by, and some supervisors are too soft on the residents, by letting them get away with things and not issuing violations, but no staff has given kids items to self-harm or encouraged it. Staff 1 denied knowledge of any staff taking residents to the elevator to discipline them or of a staff hitting or slamming any resident's head in the elevator. Nor had staff 1 heard of any staff being sexually inappropriate with a resident.

Staff 2 was not aware of any male staff being sexually inappropriate with a female resident. He indicated, "We're usually prohibited from working with them for that reason". He, said, when they did work with them it was just to fill in. Staff 2 denied awareness of any inappropriate disciplining of residents, or of staff telling residents to self-harm or providing them with things to do so.

It is noteworthy the incident youth A indicated to DHHS Worker 2 pertaining to how she got her scar was investigated via special investigation 20013C042050. And the allegation by youth B of mistreatment by staff at DBI, and staff taking kids on elevator

rides, and hitting them with walkie talkies were investigations pertaining to youth B; and were investigated via special investigation 2016C0420002, and 2016C0420005. Additionally, special investigation 2015C0420019 investigated the allegation youth B and youth C spoke of pertaining to a youth's arm being broken.

<b>APPLICABLE RULE</b>	
<b>R 400.4112</b>	<b>Staff qualifications.</b>
	(1) A person with ongoing duties shall have both of the following: (a) Ability to perform duties of the position assigned. (b) Experience to perform the duties of the position assigned.
<b>ANALYSIS:</b>	There is insufficient evidence to support the allegations of sexually inappropriateness by Mr. S, or a staff; or of staff promoting or encouraging residents to self-harm.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.158</b>	<b>Discipline.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of corporal punishment inflicted in any manner.
<b>ANALYSIS:</b>	Youth A's prior head injury, and youth B's alleged mistreatment were previously investigated as indicated in this report.  There is insufficient evidence to support inappropriate discipline or such of residents in elevators. And it is noteworthy the facility was formerly advised to pursue installing cameras in its elevator; and the chief administrator indicated the facility was following through with such.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

The entire facility is infested with cockroaches; and in February there were roaches crawling out of a water fountain.

The facility's food is gross, kids do not get enough, and a prior resident lost lots of weight while placed there; was given spoil food, and once a fly was in a resident's food.

**INVESTIGATION:**

Youth A, youth B, Youth C prior DBI residents who are currently placed at Muskegon River Youth Home were interviewed by DHHS Worker 2 related to this complaint on

4/1/16. DHHS Worker 2's interviews are indicated below; yet youths' names are now coded.

Youth A reported DBI is filthy. She, stated, there were roaches crawling out of the water fountain when she was there in February. She, reported, she had flies in her food, and her breakfast was always spoiled. Youth A stated it was so gross, she could hardly eat. She, also, stated that they would not give her enough to eat. Youth A disclosed she lost a 100 pounds the first time she was placed there, and 20 pounds her second placement. She, reported, the first placement was over a year, and the second placement was December 2015 to February 2016.

Youth A stated that once she was working in the kitchen, and cockroaches were crawling out of the drinking fountain. Youth A reported Ms. Abner saw this and tried to dump bleach down the fountain, and this caused about 30 roaches to crawl out. Ms. Abner told youth A that she would be reporting the cockroaches.

Youth B was asked if there was anything she would like to share about her time at DBI. Youth B stated she would talk about some things, but not everything. Youth B was asked to share what she was willing. Youth B reported that they were "abusive".

Per DHHS Worker 2's interview, youth B did not report any information about the facility environment or its food.

Youth C was asked about her experience at DBI. Youth C stated that things were "rocky" and she ultimately ran away from there. Aside from what youth C indicated to DHHS Worker 2 in the other section of this report, no other concerns were indicated.

It is noteworthy that a complaint about the roaches matter was investigated in February 2016 via special investigation 2016C0420016, whereby no rule violations were cited.

The matter was re-investigated during an on-site inspection by this consultant and the DHHS Worker on 4/14/16. At that time the Quality Assurance Manager, Stephanie Mitchell was spoken to, along with the Maintenance Team staff person, Synoise Clemons, and Environmental Director, Danny Williams; and four residents and three staff were interviewed and a tour of the facility was conducted.

Ms. Mitchell was not aware of an incident whereby roaches came out of a water fountain. She, indicated, the residents do not drink out of the water fountain on the floors; they drink dispense/filtered water from the water machines in OCC (Operation Control Center) rooms.

Youth D, youth E, youth F and youth G all reported having seen roaches on the premises; and only youth G reported being aware that the facility sprays for the bugs. Neither of these residents reported not getting enough food.

Youth D, indicated, the roaches, which she indicated the facility staff said are water bugs, are everywhere, group room, class room. She, said, the staff sweeps every other day, and they (bugs) are there; and that there have been multiple sightings of bugs. She, said, once there was a bug in her chicken, and that people have gotten sick from the food. She, said once, black maggots, about forty, came up from the sink in her room, because the facility staff sprayed something sweet down the drain, and she saw the maggots come up. She, said, roaches also came out of a water fountain; and the staff poured bleach down the drain.

Youth E, indicated, the program is gross; that the facility is dirty, mildewed; and there are roaches, but she has gotten used to it. She, said, the therapist, and staff do what they can for the residents. She, indicated, the food look fakes, is cold sometimes, she has found hair in it her food a number of time; and it has made her sick because of how unappetizing it is.

Youth F, indicated, she has seen gnats in her room; but she was not sure where they came from. She, indicated she sometimes see roaches; and that they have made it upstairs to the group room, as have ants. She had never seen the facility spray for bugs or put any type of powder deterrent down. As for the food, she indicated the majority of the time its cold, but it's enough.

Youth G, reported, no complaints about the food or the facility. She, reported, a complaint with "just the bugs". She, indicated they are in the kitchen, around the table; and that when they spray, the bugs come out. Yet, she denied ever seeing them spray. She, said, facility "staff, and the janitor tells us they are water bugs, but they are roaches". She, said, she has seen them lots of times, but never thirty or forty of them. She denied ever seeing them in the water fountain.

Danny Williams, reported, the facility has had someone from pest control coming out weekly since February 2016, after their last sighting of bugs, which he said was 2/17/16 in a therapist office. He, indicated, the pest control person does a walk through each time, they can't spray each time; but they will put down a powder (Python dust- which is like boric acid- and it's not toxin) every time. He, said, the powder is placed in crack areas, and anywhere there was a sighting of bugs or inspects. He, said, on about 3/22/16, and 4/1/16 there was a sighting of ants in one of the rooms, and in the program coordinator's office respectively, and treatment were done on those days.

He, indicated, roaches were not in the water fountain; and he never heard that they were. He, said, water bugs were coming up from the drains; but were not in the water fountain. When asked whether there were reports of maggot sightings, he indicated, about a month (prior to this interview) one resident reported she had maggots coming out of her sink; but they were not maggots, they were sewer gnats. He, said, the kids were pouring milk down their sinks; and that the gnats, bugs, can come up from the sewer drain, because they smell the scent. He, said since that happened they have been treating the residents' sinks with bleach weekly. He

provided documentation of the past three pest treatments by Pest Pounders; which were dated for 3/25/16, 4/2/16, and 4/8/16. The documents indicated weekly services being done, and the services done those days.

Mr. Clemens, indicated, there was a resident who said she saw bugs in the drinking fountain; he examined it; saw, standing water in the pipe trap drain, but no bugs in the water, nor any in the fountain area. He, said, since he didn't see anything, there was nothing more to do. He, indicated, some of the problems with the bugs is kids leaving food around or pouring sweet things down the sinks and, the sweet smell getting into the vents and attracting the bugs and gnats.

A tour of the facility was conducted onsite on 4/14/16; and no bugs were seen at that time. Three other staff were spoke with. Mr. S onsite; and two other staff via telephone. Mr. S denied there being a cockroach problem. He, reported, seeing a water bug here or there; but indicated he had never seen any coming out of a water fountain, which are on each floor; and which the kids do also drink from.

Staff 1 basically reported the same. Staff 1 reported he saw a few bugs, when he first started. He didn't know how often the facility sprayed for bugs, but acknowledged seeing the facility do so.

Staff 2, indicated, there are a lot of roaches, but he has seen them spraying for such more than a couple of times. He, indicated, the kids do drink from the water fountains, and sometimes kids are given a bottled water with their lunch. He had not seen or heard of any bugs being in a water fountain or coming from a water fountain.

Staff 2, as did staff 1 and Mr. S reported no problem with the food; and that residents got enough food. Staff 1 was unaware of any resident getting bad food, but if so they would not be allowed to eat it.

Mr. S, indicated food portions are of regular size; and residents may not want to eat what they get, such as their vegetables; but kids get enough to eat. He recalled youth A; and reported that the first time she was a resident at the facility, she was skinny, and when she came back she was bigger. When asked whether she recalled her losing a significant amount of weight, when she was at the facility, he indicated, "She didn't lose any weight."

Staff 2 reported no know problems with the food; he indicated sometimes there may not be enough for kids to get seconds, but kids have enough to eat. Staff 2, had never heard of any kids having roaches, worms or anything inappropriate in their food. He, indicated, if such was to occur the kid would get something else.

Quality Assurance Manager, Taneisha Henderson, recall youth A; and recalled youth A slimming somewhat once she began to get more wholesome meals and exercise. She did not recall the youth losing a significant amount of weight. Ms. Henderson provided this consultant with a copy of youth A's admission physical

assessments; which showed youth A weighed 253 pounds at admission on 3/4/13 and 261.6 pounds at admission on 12/1/15. Her 2/10/16 health discharge report was also provided, but it did not indicate the youth's weight at discharge.

<b>APPLICABLE RULE</b>	
<b>R 400.4407</b>	<b>Facility and premises maintenance.</b>
	(3) The facility, including main and accessory structures, shall be maintained so as to prevent and eliminate rodent and insect harborage.
<b>ANALYSIS:</b>	<p>No roaches, gnats or water bugs were seen on inspection; and there is insufficient evidence to support there is an infestation throughout the facility or in the water fountains.</p> <p>Some staff, as well as, the facility maintenance personnel, and the Environmental Director, Mr. Williams acknowledged that the facility has had bugs; and there are periodic sighting of them. Yet Mr. Williams reported the facility treats for these pests regularly by having pest control to come out and spray routinely; and to come out and inspect and treat for pests whenever there is a sighting.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4407</b>	<b>Resident nutrition.</b>
	(1) A licensee shall provide a minimum of 3 nutritious edible meal daily unless medically contraindicated and documented.
<b>ANALYSIS:</b>	There is not sufficient evidence to suggest this is not occurring.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

The facility is dirty.

**INVESTIGATION:**

Youth A, youth B, Youth C prior DBI residents who are currently placed at Muskegon River Youth Home were interviewed by DHHS Worker 2 related to this complaint on 4/1/16. DHHS Worker 2's interviews are indicated below; yet youths' names are now coded.

Youth A reported DBI is filthy. And per DHHS Worker 2's interview with youth B, youth B did not report any information about the facility's environment or its food. Youth C was asked about her experience at DBI. And per DHHS Worker 2's interview with youth C, aside from what youth C indicated to DHHS Worker 2 in the other section of this report, no other concerns were indicated.



Youth D, reported the facility has bugs, which she said was everywhere; and she reported no other facility environment issues. Youth E reported when she first came to the program, she thought it was gross. She, said, the facility is not clean; its's filthy, mildewed, and there are bugs, but she has gotten used to it.

Youth F was inadvertently not asked about this area of the complaint; and Youth G reported no complaints about the food or the facility. She reported a complaint with "just the bugs".

Youth Specialist, Mr. S did not report any concerns with the facility. Staff 1 reported the environment is clean, but there is lax in cleaning; and staff 2 reported the program and building is not what it should be, but he thought the building was kept cleaned, He said, maintenance is never far away when needed.

A tour of the facility was conducted onsite, by this consultant, and the DHHS worker on 4/14/16; and it is noted that the main floor visiting room was clean and shining and this consultant and the DHHS Worker noticed such. Yet the walks through of the building did not show the same. The downstairs and upstairs' door kick plates were observed to be very dirty and in need of cleaning. The same was so for the steps, some area of the hallways; a group room, the floor in the kitchen, girls' groups room, and shower, and shower walls and floor; which appeared as if it would have taken more than one day to get that way. The kitchen sinks were also observed to be in need of sanitizing, and deep cleanings. The kitchen staff person Ms. Williams indicated efforts are made to keep the area clean.

Maintenance Manager, John Baker reported the building is mopped once weekly throughout; and the hallway is swept every morning. He, indicated the resident rooms are cleaned every day, and staff spray wipe the girl showers. Mr. Baker was asked about the door kick plates, as they were observed to be very dirty; and he indicated "we don't clean them."

<b>APPLICABLE RULE</b>	
<b>R 400.4407</b>	<b>Facility and premises maintenance.</b>
	(1) A facility premises shall be maintained in a clean, comfortable, and safe condition. The facility shall be located on land that is properly drained.
<b>ANALYSIS:</b>	The facility had various areas that were observed to not be cleaned; and needed sanitizing
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4407</b>	<b>Facility and premises maintenance.</b>
	(5) Floors, interior walls, and ceilings shall be sound and in good

	repair and shall be maintained in a clean condition.
<b>ANALYSIS:</b>	Various floors, doors, hallways and the shower were dirty and in need of cleaning.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**RECOMMENDATION:**

Upon receipt of an acceptable corrective action plan, continuation of the facility's current licensing status is recommended.

June 1, 2016

_____ Lonia Perry Licensing Consultant	_____ Date
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Approved By:

June 2, 2016

_____ Linda Tansil Area Manager	_____ Date
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RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
LANSING

NICK LYON  
DIRECTOR

July 22, 2016

Derynda Winston  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2016C0420037  
Detroit Capstone

Dear Ms. Winston:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

**FOR CWL ONLY**

Please note that violations of any licensing rules are also violations of the ISEP and your contract.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2016C0420037
<b>Complaint Receipt Date:</b>	05/25/2016
<b>Investigation Initiation Date:</b>	05/25/2016
<b>Report Due Date:</b>	07/24/2016
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	1ST PROVISIONAL
<b>Effective Date:</b>	01/25/2016
<b>Expiration Date:</b>	07/24/2016
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
Resident A was sent out to Children hospital for assessment, after he broke the light fixture in his room, found a piece of glass and cut his arms.	Yes
Additional Findings	No

## III. METHODOLOGY

05/25/2016	Special Investigation Intake 2016C0420037
05/25/2016	Special Investigation Initiated - Letter Email to and from Quality Assurance Manager, T Henderson
05/25/2016	Contact - Document Received Nursing note, hospital discharge
05/26/2016	Contact - Face to Face Interviewed Resident A
06/02/2016	Contact - Face to Face Interviewed staff
06/24/2016	Inspection Completed-BCAL Sub. Compliance

### ALLEGATION:

Resident A was sent out to Children hospital for assessment, after he broke the light fixture in his room, found a piece of glass and cut his arms

### INVESTIGATION:

This consultant received an email from Quality Assurance Manager, Taneisha Henderson that indicated resident A was sent out to Children's hospital emergency room on 5/24/15 at 11:20PM. That resident A "broke glass in his room from the lighting fixture and used it to cut himself". Ms. Henderson's email indicated the nurse decided to send the resident to the hospital; because she could not stop the bleeding to one of two cuts on the resident's arms; the nurse had a hard time providing first aid due to resident A complaining of pain; and that was also why he was sent to the hospital. Ms. Henderson, indicated, resident A was released and returned back to the facility; and no stitches were needed to his cuts.

Resident A(16) said, he left his life book in the group; staff refused to allow him go get it, and he was refusing to transport to his room; but he went in his room anyway.

He, reported, he continued to complain about staff not letting him get his book; making him go into to his room; and staff, Mr. Flaniken, and Mr. AnSong, teased him. He, said, the two staff said, "So what you gone do about it, write a letter to Julie (Julie is the first name of the facility's Chief Administrator) or self-harm". Resident A said another staff Mr. Patterson laughed; and so he started self-harming. He, said, the light fixture in his room had been broken three weeks prior and it was not completely repaired, so he hit it with his fist, took glass and cut his arms; and got restrained by, Mr. Patterson, and Mr. McGuire. He, said, Mr. Patterson was upset, and said "Why, me; why you doing this stupid shit"; and they took him to the BMR (Behavioral Management Room). He, said, Mr. Pinkston arrived, switched out with Mr. Patterson, and Mr. Patterson stated "This is not by fucking resident, he's not a part of my group", as to indicate why was he having to be responsible for resident A.

Resident A, said after Mr. Pinkston talked with him for a while, he was taken back to his room; and Ms. Dunlap told Mr. Pinkston "to sit on him" (watch him). He, said, Mr. Pinkston switched out with Mr. Patterson, because Mr. Pinkston had to go put supplies away in another group. Resident A, said, Mr. Patterson did sit, but as soon as Mr. Pinkston was out the door, Mr. Patterson left the room; and "I started self-harming again". He, said, he got a piece of glass he had hidden in the room's vent area; that staff had not cleaned the floor well from before. He, said, Mr. Patterson saw him before he (Mr. Patterson) left, and Mr. Patterson told him, "You better not do that". He, stated, after Mr. McGuire and Ms. Johnson saw what he was doing, as they were doing room rounds, that's when Mr. Patterson came back in the room. He, said, there was blood everywhere; he had lots of cuts on his arms; and because of them he had to go to the hospital. He, said, he had told everyone he saw that he was going to self-harm again; that he told, Mr. Dunlap, Mr. Pinkston, Mr. McGuire and Mr. Patterson, who didn't care; and he did again.

Resident A denied being on one-to one staffing at the time of the incident; but said he was at the time of the interview with this consultant. He, indicated, the incident occurred on 5/24/16 between 9:00PM and 10:00PM; and his roommate's youth 1, and youth 2 may have seen what happened but they won't talk. It is noteworthy, both residents had discharged from the facility, when this consultant went to interview them on 6/2/16.

When asked if he saw the nurse, he, said he saw, Nurse Gaston, who wasn't going to send him to the hospital, because she thought he was trying to get out of the facility. He, said, the nurse said the doctor was coming Friday, and so she was sending him to the emergency room(ER), but then he refused treatment; and she sent him to the ER.

Youth Specialist, Dankyi AnSong denied the allegation against him. He, said, he responded to a call for assistance, and when he got on the scene, the incident was already in progress with resident A cutting himself, and being restrained. He, said, he was only involved in one incident with resident A on the date in question. He indicated, he stood in the door way; and there were two staff there, (whose names

he did not know). One staff was restraining resident A, and the other was talking with resident A, who was self-harming with a piece of glass. He, said, there was lots of blood on resident A's left arm, hand, and on the floor; and resident A was saying "I'm gonna kill myself; y'all think I'm playing". Mr. AnSong, said, he didn't see the piece of glass resident A used, until after the incident. It was on the floor. Mr. AnSong denied hearing staff tease or encourage resident A to self-harm. He, said, all the staff were telling resident A not to self-harm. When asked whether the fixture in resident A's room was broken, Mr. AnSong indicated he had never known the room fixture to not be intact, although he admitted he never looked up at the fixture.

Youth Specialist, Michael Flaniken reported, familiarity with the incident, but denied involvement in the incident. He, said, he responded to a call for assistance; and when he arrived on the scene, he saw resident A had cuts on his arms; and there was blood on the floor. Then, he said he thought resident A may have already been removed from the room, but he knew blood was on the floor, and someone was cleaning it up. When asked what staff restrained resident A and removed him from his room, Mr. Flaniken was not sure. He, recalled, one of resident A's roommates youth 1 being in the room, and that youth getting him tissue; but he said he did not know what youth 1 had seen or if he was present when resident A self-harmed.

Mr. Flaniken denied the allegations against him. He, stated, "That not something I would have said". He, denied, involvement in a second incident with resident A that evening; and reported he never works directly with resident A. He, said, as a "floater" he might talk with resident A from time to time, but they have no relationship. He, said, resident A is a resident who needs lots of attention, and if he isn't given it, he reacts by self-harming, cursing a person out, refusing to transport or refusing his meds.

Therapist, Amanda Johnson, was not present the night of the incident, but indicated resident A had been doing well, and he had just earned his level. She, suspected his self-harming act had to do with his frustration over his placement recommendation. She, said his case had recently been transferred to another therapist, but she knew he had wanted the worker to recommend his placement with his grandmother at court on 6/1/16, and he learned that wasn't happening.

Team Leader, Ebony Dunlap, reported resident A self-harmed by cutting his arms. Mr. Patterson discovered him, saw the blood; restrained him; and she had Mr. Patterson to escorted him to the BMR. She, said, she was not on the floor before resident A self-harmed, and she didn't know the full details. She was informed he had left his folder downstairs, he wanted to go get it, but wasn't allowed to, because it was bedtime; and he got upset. She, said, per Mr. Flaniken, he and Mr. Patterson told resident A to just get his stuff to transport upstairs, and they would get his folder later. That when resident A got upstairs he started cursing the staff, calling them the "B word"; and Mr. Flaniken said resident A was given a violation, which resident A questioned. Resident A said "Julie" would hear about it; then he went into his room



on his own. When asked whether resident A said he was going to self-harm at the time, Ms. Dunlap said, Mr. Flaniken, didn't say resident A said he was going to.

Ms. Dunlap, indicated, Mr. Patterson obtained the piece of glass resident A said he used to cut himself, though resident A, said he had more hidden. When asked whether resident A's room was checked for more glass, Ms. Dunlap stated "I believe it was searched by Mr. Patterson" because she recalled him showing her another small sharp piece of glass he had found. When asked whether someone examined resident A's light fixture, she, said, yes. But, she didn't believe resident A got the piece of glass from the light fixture; she said resident A broke that weeks ago; maintenance repaired it sometime ago; and resident A's roommates said resident A must have hidden it from a time before; because he went on the side of his bed and got it. She, said, the staff examined the room that night, looking under mattresses, in/around vents, wall crevices; and they only found the sharp piece of glass, she previously mentioned.

Ms. Dunlap, reported, resident A was in the BMR for a while with the door open, with Ms. Patterson, but she had Mr. Patterson to leave, because resident A doesn't like him. She, had Mr. Pinkston, whom resident A has a better relationship with, come and sit and talk with him. When asked whether there came a time another staff switched off with Mr. Pinkston, she indicated there was no switch off that Mr. Pinkston called to say resident A was ready to go back to his room, because he was calm. She, said, resident A had told her "I'm going to do this all night" meaning he was going to keep self-harming, because he wanted to go to the hospital, and he was going to run. She, indicated, she believed resident A when he said he was going to continue self-harming, and she asked Mr. Pinkston to continue sitting and talking with resident A at his open door. When asked whether there came a time that another staff switched off with Mr. Pinkston, Ms. Dunlap said "I left the floor, they didn't tell me this"; and approximately two minutes afterward, Mr. Patterson called her informing her that resident A self-harmed again. And when she asked how that was possible as it had only been five minutes since her contact, Mr. Patterson told her Mr. Pinkston asked him to sit on resident A while he (Mr. Pinkston) went to the bathroom. She, said, Mr. Patterson, said he talked to resident A; resident A said he was fine; and so Mr. Patterson closed resident A's door, and continued doing room rounds. Ms. Dunlap stated, that per her review of video footage of that night, she saw that Mr. Patterson went to two room directly across from resident A's room, then he went back to resident A's room; and restrained resident A. She, said, when resident A was being restrained, he said, "I told y'all I have glass everywhere, we'll do this all night".

When asked whether resident A's room was searched again, Ms. Dunlap said, yes. She, said, Mr. Pinkston did so; and he said he didn't find anything. She, indicated, she spoke with resident A's roommate, youth 1, and youth 1 said, after Mr. Patterson left from talking with resident A and closed the door, resident A began digging in his cuts with his fingernails. When asked why resident A wasn't placed on one-to-one supervision since he was making the self-harming threats, Ms. Dunlap indicated he

was not. She said, the therapists are the ones to place kids on one-to-one staffing supervision. When questioned couldn't she as a supervisor have made the call to provide greater supervision for resident A, since she believed him, when he said he would keep self-harming; Ms Dunlap indicated he was not on one-to-one supervision. When asked why didn't Mr. Patterson continue to supervise resident A as instructed, Ms. Dunlap indicated, Mr. Patterson wasn't there when she gave Mr. Pinkston those instructions; and when Pinkston asked him( Mr. Patterson) to talk with resident A and resident A said he was ok, Mr. Patterson thought it was ok to leave resident A. She, said, she gave Mr. Patterson a written counseling for not using common sense/for showing poor judgement; because even though resident A was not on one-to-one supervision Mr. Patterson should have stayed with resident A.

Ms. Dunlap, indicated resident A was seen by the nurse; and the nurse said resident A opened his wounds deeper; he might need stitches, so he needed to be sent to the hospital.

Youth Specialist, Terrial Pinkston recalled the incident. He, said, he got a called to verbally de-escalate resident A, because of him having a good relationship with the youth. That Ms. Dunlap radioed him and asked him to sit with resident A; and when he got on the scene, Mr. Patterson was in the BMR room with resident A. He, said resident A's arms were bleeding; he didn't know what had happened; but resident A was pacing back and forth, so he paced with him; and talked with him about what happened. He, said, resident A was angry at Mr. Patterson, but also angry at other staff; and he tried to help resident A process things He, said, ten minutes later Mr. Patterson returned to the BMR; and asked resident A if he was ok, but resident A cursed him. Resident A told Mr. Patterson everything was his fault; and Mr. Patterson said, "I can't let you self-harm; and I'm not going to go back and forth with you" arguing. Mr. Pinkston, said, Mr. Patterson was not inappropriate with resident A, and Mr. Patterson never said anything negative or derogatory to resident A. He said, Mr. Patterson only asked resident A why was he putting blood on the wall.

When asked whether there came a time he asked Mr. Patterson to switch out with him; Mr. Pinkston, said, he asked Mr. Patterson if he would sit with resident A while he took a bathroom break. He, said, he returned five to ten minutes later; and Mr. Patterson was with resident A; and he relieved Mr. Patterson. When asked who took resident A to his room from the BMR, Mr. Pinkston indicated he had before he went to the bathroom. He, said the incident began sometime between 9:30PM and 10:30PM and continued on; and that before he left for the night, resident A was in the waiting area waiting to go to the ER.

Youth Specialist, Jason McGuire, recalled the incident. He, said, staff, Ms. Johnson was conducting rounds, and she alerted him that resident A was in his room self-harming. Mr. McGuire entered resident A's room, and Mr. Patterson had resident A in a restrained. He, said, resident A's arms were behind his back; and the restraint was properly done. He, said, resident A was not chicken winged. He switched off

with Mr. Patterson in the restraint, and Mr. Patterson went to get gloves. He, said, He, indicated, he kept resident A in the restraint until Mr. Patterson returned with the gloves. He, said resident A was screaming about self-harming, and what he was going to do to his himself; but resident A was not resisting the physical management. When asked what if anything did Mr. Patterson say to resident A during that time, Mr. McGuire couldn't recall Mr. Patterson's words; but, stated, Mr. Patterson said things to try to de-escalate resident A. He denied, Mr. Patterson teasing, or cursing the youth, or saying anything derogatory. He, said, Mr. Patterson escorted resident A to the BMR; and he (Mr. McGuire) searched resident A's room during that time; but he did not find anything.

When asked if there came a time when resident A was taken back to his room, and resident A self-harmed again, Mr. McGuire said, yes; but he could not recall what resident A self-harmed with. He called being in the BMR with resident A at some point, but he couldn't call if that was the first time, second time or another day; because he didn't recall a second incident that night where resident A's cuts got cut deeper.

Youth Specialist, Barry Patterson, recalled the incident. He, said, he was doing rounds, Ms. Johnson informed him resident A was self-harming and he restrained resident A.. He denied chicken winging the youth. He, indicated he didn't fully restrain youth A, and he took a piece of glass from him. He, said, blood was running down one of the youth's arms; and resident A was going on about a lot of stuff, and threatening to continue to self-harm. When asked what did he say to resident A, Mr. Patterson stated he said "give me the glass"; and resident A told him it was on the floor; and he (Mr. Patterson) found it. He, said, when Mr. McGuire entered the room he (Mr. Patterson) was standing there holding resident A's arms in the PRT (physical restraint technique); and resident A was not resisting. Then he switched out with Mr. McGuire, went for gloves; and when he returned, he or Mr. McGuire escorted resident A to the BMR. He, denied saying anything such as why are you doing this stupid shit, or this isn't my fucking resident; or laughing at resident A for self-harming. He, said, "I was kind of freaked out, this was the first time I'd seen something like that"

When asked whether there came a time, that another staff asked him to sit and watch resident A while they took a bathroom break, Mr. Patterson acknowledged that to be true. He, indicated, that wasn't when resident A was in the BMR. It was when resident A had returned to his room; and Mr. Pinkston was sitting with the resident. Mr. Pinkston asked him to do so. Mr. Patterson, said he stayed with resident A for a while, and he tried to find out what was going on with him; but resident A wanted him to get out of his room. When asked whether resident A asked him to get out of his room, Mr. Patterson said, "No, he stop talking to me. I asked him if he was fine; and he said yes"; and Mr. Patterson went to check on residents in the room across the hall, because they were beating on the door. He said, he returned to resident A's room a couple of seconds later, and "he was self-harming again. Where he got the glass from I don't know." Mr. Patterson was not

sure if he was the one to discover resident A self-harming again; or if Mr. Pinkston had come back and discovered it. When asked why he didn't stay with resident A until Mr. Pinkston returned, Mr. Patterson stated "I wasn't clear, I didn't know I was to stay the entire time." When asked hadn't resident A threaten to self-harm again, he acknowledge that was true; he said he had swept resident A's room himself; and there was only one bit of glass found. He, said, he spoke with resident A's roommates, but they never told him anything. When asked if the piece of glass was from the resident's light fixture, Mr. Patterson said he couldn't tell; but he didn't see any missing pieces from the resident's light fixture, nor was he aware that youth's fixture had been broken prior.

Mr. Patterson acknowledged receiving a disciplinary write up for his action in this incident.

**Reviewed:**

- Nursing email note from Nurse Diane Gaston, dated 5/25/16 for 11:16 PM that indicated: on 5/24/16 at approximately 9:15PM she was summoned to the BMR, as, per the staff, resident A had self-harmed with a piece of glass. The assessment revealed multiple superficial lacerations and scratches, with one to two lacerations appearing to be somewhat deep on the right inner and outer forearm. The nursing note indicated, Nurse Gaston cleaned the arm, but resident A refused antibiotic ointment, and analgesic, though he rated his pain 10/10. The nursing note indicated approximately three to five minutes later, Nurse Gaston was summoned to the BMR again, due to resident A self-harming again with another pick of glass. That she observed resident A spreading blood over the window in the BMR, and he stated "I don't care if I get an infection". That resident A refused to be assessed this second time, which was at 9:20PM. That at that time both of resident A's arms and hands were covered in blood. That at 10:00PM resident A was brought to the nursing office, at which time he allowed nurse Gaston to cleanse the wounds and arms. That bleeding persisted, but appeared to be subsiding; and resident A had removed the large bandage she had applied during the first assessment. That two of his lacerations appeared to require evaluation by an ER physician; and resident A was being sent out. Additionally that notifications were made to DHHS and other persons.
- Children's Hospital of Michigan-Emergency Department Discharge Instructions dated 5/25/16.
- Observed the lighting fixture in resident A's room, which was intact and did not appear damaged; and if it had, this consultant could not see glass parts or how any glass would have come from the fixture due to how it is constructed.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(3) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and

	shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS:</b>	<p>The evidence showed:</p> <ul style="list-style-type: none"> <li>• Resident A a known self-harmer cut and scratched his arms in several places with glass he had hidden in his room; and he was restrained and escorted to the BMR room.</li> <li>• Resident A informed various staff he had other glass hidden in his room; and that he would continue to self-harm. The team leader reported believing resident A, and asked a staff to sit and talk with. Yet the supervision and monitoring was not maintained when resident A was allowed to return to his room, where he self-harmed again with another piece of glass.</li> <li>• The agency failed to provide the supervision and monitoring resident A required at the time, given his behavior and threats at the time; and this enabled him to self-harm again within a short period of time after his first episode. Therein, resulting in him causing a greater degree of injury to the cuts on his arm, and needing an ER assessment and treatment.</li> </ul>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4158</b>	<b>Discipline.</b>
	<p>(2) An institution shall prohibit all cruel and severe discipline, including any of the following:</p> <p>(a) Any type of corporal punishment inflicted in any manner</p> <p>(c) Verbal abuse, ridicule, or humiliation.</p>
<b>ANALYSIS:</b>	The evidence does not support the allegations.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan continuation of the facility current licensing status is recommended.

July 21, 2016

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Lonia Perry  
Licensing Consultant

Date

Approved By:

July 22, 2016

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Linda Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
LANSING

NICK LYON  
DIRECTOR

October 26, 2016

Derynda Winston  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2016C0420049  
Detroit Capstone

Dear Ms. Winston:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

**FOR CWL ONLY**

Please note that violations of any licensing rules are also violations of the MSA and your contract.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure



**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2016C0420049
<b>Complaint Receipt Date:</b>	09/08/2016
<b>Investigation Initiation Date:</b>	09/09/2016
<b>Report Due Date:</b>	11/07/2016
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	2ND PROVISIONAL
<b>Effective Date:</b>	07/24/2016
<b>Expiration Date:</b>	01/23/2017
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
The agency gave youth A psychotropic medications without the child's parent's consent.	Yes
Additional Findings	Yes

## III. METHODOLOGY

09/08/2016	Special Investigation Intake 2016C0420049
09/09/2016	Special Investigation Initiated - Telephone Left Message for Complainant
09/19/2016	Contact - Telephone call made Left Message for Complainant- no resident name on complaint
09/19/2016	Contact - Face to Face Spoke with Nurse Patricia Perry, reviewed med file, phone call with Nurse manager, Tubbs,
09/21/2016	Contact - Telephone call made Left message for youth A mother, Parent A
09/21/2016	Contact - Telephone call received Message from Youth A, worker, Ms. Wyatt
09/21/2016	Contact - Telephone call made Message left for Ms. Wyatt
09/22/2016	Contact- Telephone call made Spoke with Youth A's Mom
09/22/2016	Contact - Telephone call received From Ms. Wyatt
09/23/2016	Contact - Telephone call made Left Message for Ms. Wyatt
09/23/2016	Contact- Telephone call made Spoke with Nurse, Gaston
09/23/2016	Contact- Telephone call made Left message for Nurse Practitioner, G. Johnson
10/19/2016	Contact- Telephone call made Left message for Nurse Practitioner G. Johnson
10/19/2016	Inspection Completed-Sub Compliance
10/24/2016	Exit Conference

**ALLEGATION:**

The agency gave youth A psychotropic medications without the child's parent's consent.

**INVESTIGATION:**

The Complainant's document indicated Detroit Behavioral Institute (DBI) began providing medications to a foster care youth (temporary ward) without the proper authorization/consent signatures from the child's mother. It indicated forms were presented to the Department of Health and Human Services Caseworker for consent signatures following the youth's placement at the facility; and that those forms were forwarded to the child's mother for review and signature, and then returned to DBI. It was indicated that DBI subsequently sent the DHHS Caseworker the same consent forms, with an additional form for psychotropic medications. The forms that had previously been signed by the child's mother were re-sent to DBI, and a follow up telephone call was made regarding the psychotropic medication consent needing to be filled out with the mother's information and sent to her. The mother's email was provided to expedite the process. The child's mother was unwilling to consent to the psychotropic medications, and did not sign the forms.

The complaint document indicated that approximately a week later, the child's mother notified the DHHS Caseworker that DBI had been dispensing medications that had not been consented to by the child's mother. The mother contacted the nursing department at DBI and informed them that she had not consented to the medications.

Nurse Patricia Perry, indicated the department obtained a verbal consent from youth A mother on 9/6/15 for multivitamin which is the only thing youth A's receives. She, said, youth A was receiving two other medications, Seraline 25mg and Zoloft; and youth A received one or both of them into 9/1/16, when youth A's mother said she doesn't want youth A on meds.

Nurse Perry, explained, that normally if a child comes in on a certain medication the doctor continues the child on those medications. Nurse, Perry acknowledged that was not the case with youth A, as youth A was not on medications. She, said, the doctor saw youth A, and he prescribed Zoloft; but Nurse Perry was not sure if that was a previous medication youth A had been prescribed before, or if this was a new medication for her. She, said, all she knew was youth A is no longer on other medications.

While reviewing youth A's medical file, it showed that on 8/16/16, youth A was prescribed Zoloft, 25mg every morning and Trazodone 25-150mg orally at bed as needed. Nurse Perry was asked why the wide dose range on the latter medication, and she indicated it was done so that the doctor can have the preauthorization to adjust the medication as needed. She, said, though, the goal is to get what medication was needed for the youth.

Youth A reported she is currently not on any medication, except vitamins. When asked whether she was previously on any medications since she's been at the facility, youth A indicated yes. She, said "I requested Zoloft and Trazodone, because I was having a hard time sleeping. She, said, her roommate had threatened to hurt her in her sleep; and though she believed her roommate was just talking, and may not hurt her, she couldn't sleep. She, said, "I thought Trazodone would help me sleep; and I thought since I was depression, and having a hard time that the Zoloft would take the edge off." She, indicated, she told the doctor, requested the meds; and they said, yes.

When this consultant asked whether the doctor she saw was a male psychiatrist, youth A indicated it was a Caucasian woman that comes every thirty days to see kids. Youth A could not recall that person's name, nor knew if the person said she was a doctor, or was working with someone else. Youth A, said, she took the two medications for two or three weeks. She, said, "When they sent the papers for my mom to sign, my mom said I didn't need them, which is true because my mom knows I'm not a depressed person." When asked whether she knew why the facility did not get her mom's signature before she took the medication, youth A stated "They assumed my caseworker was my guardian"; and sent consent to her case worker "Heather". Youth A didn't know if the caseworker signed the consent. She said, "I ended up taking the medications two days after, and I doubt Heather signed the papers that quickly, because she does not work that fast." When whether she knew who told the facility "Heather was her guardian, youth A stated, "I told them my mom, but that it could be the state." She, said, she had been on the run a lot, and someone said it could be the state.

Nurse Manager, Alicia Tubbs acknowledged youth A had been prescribed Zoloft and Trazadone. She, indicated youth A told Nurse Practitioner, Geneva Johnson, she (Youth A) was feeling depressed and could she get something; and the nurse practitioner recommended the medications. She, indicated the youth's initial psychiatric evaluation was done by the psychiatrist; and the nurse practitioner would have seen youth A after thirty day, because Nurse Practitioner, Johnson completes a review for the residents every thirty days. She, indicated, that at the thirty day review, Nurse Practitioner, Johnson would assess, and report on new matters the youth would complaint about.

When asked how it was that the nursing staff would not have obtained the mother's consent for the medications beforehand, Nurse Tubbs indicated they had never heard of the mother until it came time to get consent for the stated medication. She, said youth A's worker had given consent for everything else; and so after going back and forth with the worker to try to get consent, the worker said the mother had to sign it. She, said between she and Nurse Gaston a couple of emails were sent to the mother, but the mother never responded. When asked for clarification as to the number of email sent the mother, Nurse Tubbs, acknowledged a total of two emails were sent youth A's mother about the medication; but they had not received the mother's consent.

Clinical Director, Dawn Revyn, was asked how is it the nursing department might not know that a youth's parent was their guardian. She, indicated all youth referrals are reviewed by Ken Tyson for appropriateness, then referral packaged goes to Ms. Beamer for further processing; then at intake the youth specialist meet with the youth for facility processing with clothing etc. She, said, the nursing staff sends for consents; and normally sends it to the DHHS (Department of Health and Human Services Worker) listed on the child's contact sheet. When asked why wouldn't youth A's parent have been listed on youth A's contact sheet, Ms. Revyn was not sure. She, indicated the nursing unit should know that information, but they may not have had the information. She, said then they were sending the information to youth A's mom, and the mom was not responding, so that's why they got the DHHS worker involved.

Youth A' mother, parent A said the allegation is true, that the facility gave youth A psychotropic medication without her consent. When asked whether the facility contacted her about this, she, said, "yes, they sent me an email with a consent form; but I did not respond or sign it or anything; and no one called me" When asked directly whether anyone called her about the matter, she stated "no". She, said, then she was talking with youth A by telephone on 9/1/16, and youth A told her she was taking two psychotropic medications. Parent A, said, she responded to that news by saying "That's illegal". She, said, twenty minutes thereafter Nurse Gaston called her; and she told Nurse, Gaston, she didn't signed any forms for youth A to be on the medications; and she didn't agree with youth A being on medications. She, said, youth A said she'd been on the medications several days, but youth A didn't really give a timeframe; and she(Parent A) didn't recall whether Nurse Gaston stated how long youth A had been on the medications. Parent A, said, she asked the nurse what doctor prescribed the medications; and she was told it was youth A's therapist (Aleksandra Nedelkoski), and it was based on what youth A said about not being able to sleep. Parent A, said, there's no reason for youth A to be on medications.

When asked whether there was ever a time she gave verbal consent to the facility for youth A to takes these medications, Zolof and Trazodone, or others, parent A said, "the only verbal consent I gave was for Midol, and over the counter stuff". She said, youth A is at the facility "because she's all screwed up in the head, but she doesn't need any psychotropic meds, there's no diagnosed reason for it". Parent A stated, "I never gave verbal consent before"; and when she returned the form, she said she wrote a big No on it. She, indicated, the other concern she had was that on the consent form a box was checked that she talked with the psychiatrist; but she said " I never spoke with anyone until September 1, when Ms. Gaston called". She, said, when she didn't respond to the email, the facility should have taken that as a no. When asked whether youth A had been on psychotropic medications before, parent A reported "They tried to put her on meds at Pinecrest, but that was for twelve days for Bipolar, but she is not Bipolar. She, said, in the past any time youth A had been on medication, the facility contacted her in advance, the doctor spoke with her, explained the medications and why they wanted to prescribe it; and they

got her consent. She, said this is the only agency that went ahead and gave youth A medications without her permission.

Nurse Diane Gaston, indicated she did youth A, admission, which the file listed as 7/6/16. She, said, youth A arrived with two DHHS social workers, and no paper work; and so all they had was what youth A reported; and youth A stated she was a state ward. She, said, when she asked who gets consent forms she was told the social worker; which is why the form were sent to the social worker. She, said youth A saw the nurse practitioner; and told the nurse practitioner she couldn't sleep, she was depressed; and the medications were prescribed and ordered. Nurse Gaston said, youth A was started on the medications on 8/18/16.

Nurse Gaston indicated, the first time, she found out youth A's mother was involved was after youth A was on the Trazodone; when during medication pass youth A walked up to the med cart, and said her mom said she couldn't take it anymore. She said, youth A also said she don't want to be on the medication; and she wouldn't take them. Nurse Gaston, thereon, called parent A and was able to speak with her; and parent A said no one contacted her; and she goes not give consent for youth A to be on the medications. Nurse, Gaston said she informed parent A, Nurse, Tubbs sent her the DHS 1643 consent form, but she never returned it; parent A said, "yes I have it, and will complete it now". Nurse Gaston, said all she could do was apologize and stop the medications. She, indicated, parent A returned the consent form and wrote NO, on the form, and said she was denying the medications. Nurse Gaston indicated, she noted this refusal on the MAR's form (Medication Administration Record) and alerted the appropriated parties.

When asked whether the DHHS worker ever signed a consent for the psychotropic medications, Nurse Gaston said she was not sure, but the charts showed consent was sent to the worker. She, indicated, the nursing unit doesn't find out whether the kids are wards of the state or what until later on; and so they will send the consents to the worker for the worker to get them to the parent for signature. When asked then who got the basic consents that were signed, signed by parent A, Nurse Gaston was not sure, but acknowledged parent A signed off on them. When asked why was medications started without verbal or written consent. Nurse Gaston indicated the medications were started to avoid a delay in treatment. She, indicated if a child is already on a medication, when they are admitted, and they can't get consent from the guardian, they will make a note in the chart that the medication was done, at the time, to avoid a delay in continued treatment. Then they will follow up on getting the written consent. She, indicated that with youth A's situation, based on what youth A stated, they didn't want to avoid a delay in her treatment.

**Reviewed youth A's case file which showed:**

- A DHS-3600 Case Referral and Acceptance for Detroit Behavioral Institute-Serenity program,; dated 7/5/16 for youth A, which listed youth A's legal status as TCW( temporary court ward), and indicated Kalamazoo DHHS as the ongoing MDHHS supervising placement agency.

- An email Nursing note from Diane Gaston, to the nursing staff, and various staff persons and administrators dated 7/6/16, that indicated youth A arrived at the facility as a new intake; and she indicated what was assessed at that time, and youth A's reactions and behaviors at the time. This email document indicated "Resident admits to having a history of self-harm and attempted suicide. Presently resident denies having suicidal/homicidal ideations. Consents to be obtained. Resident has been logged on Dr. Bryant's book for initial health appraisal; and Dr. Raman's book for initial psychiatric evaluation."
- A Capstone Academy data form that listed Parent A's name, and address.
- A Capstone Academy Medical Permit (general medical treatment consent) signed by parent A, dated 7/20/16, that listed the Parent A, named address and telephone number.
- Copy of an Initial Psychiatric evaluation by Dr. Sanjeev Venkataraman(AKA Ramen), dated 7/12/16. This evaluation indicated youth A was not on any present medications; listed her diagnoses as Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Parent/Child Relational Problem; R/O Conduct Disorder, Polysubstance Use Disorder(Cannabis & Nicotine); and Borderline Personality Traits. The Plans' section of this evaluation indicated patient needs very close monitoring; and if any clinical signs and symptoms are apparent, patient should be considered for mood-stabilizing agent; patient may benefit by careful assessment for ADHD signs and symptoms, and appropriate treatment. And that they will carefully monitor the need for antidepressant medication; and patient prognosis is guarded given patient's resistance to medication treatment, and her significantly long history of non-compliance with treatment recommendations.
- A Psycho-social Intake Assessment Initial documentation form completed by Therapist, A. Nedelkoski with a completion date of 7/18/16. This document indicated youth A named previous diagnoses of "ODD, General Mood Disorder"; and past psychotropic medication, as Risperdal. That youth A denied current suicidal and homicidal thoughts; indicated the last time she hurt herself was three years ago; and that the last time she lived with her family, which consisted of her mom, brother and her mother's husband was in March 2016. This document indicated youth A's legal status as TCW since 7/12/15.
- A Psychotropic medication informed consent (DHS-1643), that listed a 7/12/16 appointment dated for Dr. Sajeew Venkataraman, showed a copied sticky note on the form which stated "emailed to mom 8/19/16". This form listed the youth's legal status as permanent ward of the state; listed the prescribed medication as "Zoloft 25mg orally every morning (with a "25mg-2000" dosage range), and "Trazodone 25mg orally at bedtime as needed" (with a "25mg-150mg" range). This document was signed by youth A "7/18/16"; but not signed by parent A or a DHHS worker. Under the Consent where it denoted the diagnoses, target system's, reason for medication, other alternative treatments, possible side effect, and testing needed before or

- while on the medication, the boxes “Discussed with physician via telephone” and “Physician provided written documentation” are checked.
- A Medication Review form dated 8/18/16 completed by Nurse practitioner, Geneva Johnson. This document listed the same diagnoses listed on the initial psychiatric evaluation; listed the clinical conditions as “patient states she is doing generally well. Will be a sophomore next Friday. Sleep is delayed appetite is poor. States she is depressed, therapy is helping. Is agreeable to an antidepressant.” This Review also noted the youth was not on any current medication; that she was orientated in all four spheres, she is dysphoric, and she showed good insight and judgment, and there were no evidence of hallucinations or delusions, or suicidal or homicidal ideation. The recommendation listed was Zoloft 25 mg at Am; and Trazadone 25 Mg as PRN
  - A MAR sheets for youth A for the month of August and September 2016, that showed youth A received Zoloft medication at 7:00 AM daily beginning 8/18/16 until 9/1/16; and received Trazodone 25 mg at 7:00PM daily beginning at 8/18/16 until 8/31/16.
  - An email from Nurse Tubbs to Parent A dated 8/19/16 at 2:39pm stating that enclosed were two consents that needed to be signed; to please signed and either email or fax back. The email from parent A dated 9/2/16 at 9:27 AM to Nurse Tubbs and DHHS Worker with a cc to Nurse Gaston was also attached, that indicated attached was the denial to the requested medication; and to “Please DO NOT give her any medication that is not approved by me.”
  - A DBI “Physician’s Medication And Order Form” dated 8/18/16, signed by Nurse Practitioner G. Johnson, for Zoloft 25 mg and Trazodone 25mg.
  - A DBI Consent to Administer Medication form for youth A that listed Zoloft and Trazodone medications, prescribed for mood stabilization, and Insomnia. This form was not signed by parent A or the DHHS Worker, it had a handwritten statement at the bottom of it date 9/1/16 signed by Nurse Gaston that indicated at 8:30PM the mother, parent A refused to give consent. Medication stopped.

<b>APPLICABLE RULE</b>	
<b>R400.4142</b>	<b>Health services; policies and procedures.</b>
	(1)An institution shall establish and follow written health services policies and procedures address all of the following: (e) Dispensing medication.
<b>ANALYSIS</b>	The agency’s policy indicates the contracted psychiatrist shall involve the resident, when able, or their parent or guardian, in making decisions related to medications. The parent or guardian will sign medication approval forms for all medications, and verbal approval will be obtained for all medication prior to administration; and physical signature obtained within 2 weeks.



	<p>It was clear, per case documentation that youth A is a TCW; and parent A is her guardian. Thus that contact to parent A after recommendation of the prescription, and prior to the administration of the two psychotropic medications should have occurred; but did not. Parent A was not included in the decision to place the youth on medications; nor was verbal consent obtained prior to administering the medications on 8/18/16, as required by agency policy.</p> <p><b>Technical Assistance</b> The agency was apprised its policy is not congruent with the DHHS's relate to timeframes. The agency was apprised when the treatment recommendation is made for psychotropic medication, and immediate verbal consent is obtained, written consent shall occur within seven calendar days, as required by DHHS policy.</p>
<b>CONCLUSION</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R400.4152</b>	<b>Initial documentation.</b>
	<p>At the time of admission , all of the following shall be in the resident's case record:</p> <p>(g)Authorization to provide medical, dental, and surgical care and treatment as provide by section 14 a(1), (2), and (3) of 1973 PA 116, MCL 722.124 a</p>
<b>ANALYSIS</b>	<p>The authorization to provide medical, dental, and surgical care and treatment was not obtained within 24 hours of youth A's admission. The parent did not sign until 7/20/16.</p> <p>The agency utilizes an old Children &amp; Family Services, Wayne County Juvenile Justice(CFSWCJJ) Consent to Emergency and Routine treatment form (that lists Robert Ficano, as the County Executive) and that contains a rubber stamped signature of the CFSWCJJ Director's, Daniel Chaney, where the agency fills in the date; and this form was also used for youth A. Use of this form was not appropriate for youth A a TCW who was not referred via the Care Management Organization. Robert Ficano is no longer the County Executive, and it is unclear if Daniel Chaney continues to hold his position. Further many of the children are not placed by Wayne County, therefore Wayne County officials cannot give permission for their care.</p>

	<b>Technical assistance</b>  The agency was apprised that use of this form is also not appropriate for use for any resident from out of state, or children that are not placed at the agency by Wayne County.
<b>CONCLUSION</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>Contract/Policy FOM 801</b>	<b>Psychotropic Medication in Foster Care.</b>
	<b>Prior to Prescribing</b> Prior to initiating each prescription for psychotropic medication the following must occur: <input type="checkbox"/> The prescribing clinician must explain the purpose and effects of the medication in a manner consistent with the individual's ability to understand (child, and/or parent/legal guardian, if applicable).
<b>ANALYSIS:</b>	Parent A was not explained the purpose and effects of the medication being prescribed to youth A.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>Contract/Policy FOM 801</b>	<b>Psychotropic Medication in Foster Care.</b>
	<b>Urgent Medical Need</b> The role of non-pharmacological interventions should be considered before beginning a psychotropic medication, except in urgent situations such as: <input type="checkbox"/> Suicidal ideation. <input type="checkbox"/> Psychosis. <input type="checkbox"/> Self-injurious behavior. <input type="checkbox"/> Physical aggression that is acutely dangerous to others. <input type="checkbox"/> Severe impulsivity endangering the child or others. <input type="checkbox"/> Marked anxiety, isolation, or withdrawal. <input type="checkbox"/> Marked disturbance of psychophysiological function (such as profound sleep disturbance)
	<b>INFORMED CONSENT</b> Consent is required for the prescription and use of all psychotropic medications for all children in foster care. The

	<p>supervising agency must obtain informed consent for each psychotropic medication prescribed to a child in foster care. An informed consent is consent for treatment, provided after an explanation from the prescribing clinician to the consenting party of the proposed treatment, expected outcomes, side effects, and risks. The DHS-1643, Psychotropic Medication Informed Consent, <b>or</b> the prescribing clinician's alternative consent form that contains all of the required elements of the DHS-1643 as determined by the FC-PMOU, must be used to document this discussion between the prescribing clinician and the consenting party. Either form must be completed in entirety ...,</p>
<b>ANALYSIS:</b>	<p>Youth A was prescribed and administered Zoloft and Trazadone medication without a signed DHS-1643 consent form being obtained from youth A's , guardian, parent A.</p> <p>Additionally, there was no documentation that the role of non-pharmacological interventions was considered before beginning youth A on Zoloft and Trazodone. The agency's medication review form used to complete a thirty day assessment of the youth indicated therapy was working; and none of the urgent situation exceptions, as described by this standard, were documented.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan continuation of the facility's current license is recommended.

October 24, 2016

\_\_\_\_\_  
Lonia Perry Date  
Licensing Consultant

Approved By:

October 26, 2016

\_\_\_\_\_  
Linda Tansil Date  
Area Manager



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
LANSING

NICK LYON  
DIRECTOR

January 13, 2017

Derynda Winston  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: 2017C0420006  
Detroit Capstone

Dear Ms. Winston:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

**FOR CWL ONLY**

Please note that violations of any licensing rules are also violations of the MSA and your contract.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

Enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT  
AMENDED**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2017C0420006
<b>Complaint Receipt Date:</b>	11/23/2016
<b>Investigation Initiation Date:</b>	11/28/2016
<b>Report Due Date:</b>	01/22/2017
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	2ND PROVISIONAL
<b>Effective Date:</b>	07/24/2016
<b>Expiration Date:</b>	01/23/2017
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
Youth A alleged staff Mr. Solomon intentionally tried to break his arms when he was transported to the behavioral management room; and slammed his head into the doorway	Yes
The youth also alleged Mr. Solomon was calling him the N-word and faggot.	No
Additional Findings	No

## III. METHODOLOGY

11/23/2016	Special Investigation Intake 2017C0420006
11/28/2016	Special Investigation Initiated - Telephone Spoke with Administrator - incident report requested
11/30/2016	Contact - Face to Face Interviewed Youth A, spoke with Quality Assurance/Risk Manager Taneisha Henderson
11/30/2016	Contact - Face to Face Reviewed video footage
12/02/2016	Contact - Document Sent Follow up- requested staff contact numbers
12/13/2016	Contact - Telephone call made Spoke with Staff Gary Solomon
12/13/2016	Contact - Telephone call made To Mr. Holmes, left message
12/13/2016	Contact - Telephone call made To Ms. Revyn, left message
12/13/2016	Contact - Telephone call made Spoke with staff Kyshaun Turner
12/14/2016	Contact - Telephone call made Spoke with Clinical Director, Dawn Revyn
12/19/2016	Contact - Face to Face Spoke with staff Marcus Holmes
12/21/2016	Contact - Face to Face

	Spoke with staff Lamar Howard
12/21/2016	Inspection Completed-BCAL Sub. Compliance

### **ALLEGATION:**

Youth A alleged staff Mr. Solomon intentionally tried to break his arms when he was transported to the behavioral management room; and slammed his head into the doorway.

The youth also alleged Mr. Solomon was calling him the N-word and faggot.

### **INVESTIGATION:**

Youth A reported almost fighting with his peer; and then getting upset after Mr. Solomon; and his therapist confirmed to him his action was a violation. Youth A reported disagreeing with the staff's decision about the violation; because he felt they did not see his peer flipping him off or saying "fuck me to my face" under his breathe. He, indicated, after the incident with his peer, he left the group room, that staff tried to stop him, but he left the group room. He, said, staff thought he was going toward a door that lead to the Matrix hall, but he went out a door that is normally locked at the Horizon unit that leads to the OCC (Operation Control Center). Youth A initially said he was able to go out the door behind Ms. McConnico, when she walked out; because the door did not close behind her. Yet he also said he used his force to open/get out the door. He, said, Mr. Solomon had tried to follow behind him; and he pushed pass Mr. Solomon. He, indicated, after he (Youth A) was at the door he had his hand on the door; Ms. Revyn stopped him; tried to talk with him; and that was when Mr. Solomon, Mr. McClendon, and another staff whose name he did not know;(whom he described as a short, fat male with short hair) restrained him.

Youth A denied struggling in the restraint or fighting or cursing staff during the time that he was being restrained or prior to it. He denied staff telling him to close the door or to stop; he reported the staff just restrained him. He, said, as the staff was taking him down the hall, Mr. Solomon whispered in his ear "that was a bitch made move", which youth A indicated meant "Bitches go to the BMR (Behavior Management Room). He, said, Mr. Solomon said "that's why you got your dick sucked by" youth B (named here for identification in this report). He, indicated, Mr. Solomon made the statements about youth B after he (Youth A) had gotten through the door behind Ms. McConnico.

Youth A, stated Mr. Solomon and Mr. McClendon "were flying me down the hall, because my feet weren't touching the ground". He, said, when they got him through the door, Mr. Solomon pushed the side of his (Youth A's) head into a metal door; which caused a mark to his head. Youth A showed this consultant a small somewhat healed scratch mark on his right temple near his cheek bone. When asked whether anyone saw Mr. Solomon push his head to the door, youth A stated "I don't think so". When asked whether he told Mr. Solomon, Mr. Solomon had bumped or pushed his head into the door, youth A stated "No I was crying." When asked what Mr.



McClendon did, youth A indicated Mr. McClendon had not done anything at that time. He, said, when the two staff got him to the BMR "Mr. Solomon was trying to break my arms, because he was pushing them up to my head; and Mr. McClendon watched out." When asked why would he say Mr. McClendon watched out, youth A indicated, because Mr. McClendon didn't say anything until Ms. Revyn came on the scene, then "Mr. McClendon said, stop, stop, Ms. Revyn's coming" . Youth A, said he (youth A) was screaming you're gonna break my arm"; and "Please don't hurt me". Youth A denied Mr. McClendon pushed his arms up, or that any resident saw what happened. He admitted seeing the nurse after the restraint, but said he was crying and did not want to talk with her.

Youth A, indicated, he and Mr. Solomon had an up and down relationship before the incident. He, said, he didn't have a problem with Mr. Solomon; but Mr. Solomon "kept saying gay stuff to me"; and he took that as Mr. Solomon trying to hurt him.

Youth Specialist, Henry McClendon, indicated, familiarity with youth A; but denied, the allegations pertaining to him; and denied being present during the time youth A was restrained, by Mr. Solomon, or was escorted to the BMR. He, indicated, he has worked with Mr. Solomon, and Mr. Holmes, (who are named on the 11/22/16 incident report along with Ms. Revyn as present/ connected to this allegation); and he is familiar with Ms. McConnico, (whom youth A named related to this incident); but he did not know he was named as being involved in the incident. He, indicated his connection was basically that of Mr. Holmes being his work partner, and he (Mr. McClendon) heard via Mr. Holmes there was an incident; but he did not heard what that incident was about.

Youth Specialist, Mr. McConnico employed at the facility for just over six months, reported awareness of the incident; but said she was not involvement in it. She, said, she was on a one-to-one with youth B; whom she had taken to his room; and that she never left. When asked when she took youth B to his room did youth A come through the door behind her, Ms. McConnico stated "I don't remember". She, said, she had youth B and "I didn't heard anyone come behind me." She, said, she was paying attention to youth B; and that it could have happened, but she didn't see it.

She, said, youth A had been upset that afternoon of the incident; and he said he was called gay by his peer, and that he was not going to his room for reflection. She, indicated, after youth A was informed he was getting a violation, youth A gotten madder; but she didn't know what happened after that, because she took youth B to youth B's room. She, said, youth A was being redirected by Mr. Solomon and Mr. Roberts after youth A left the group room and was in the hallway. She was not sure whether youth A was still in the hallway when she escorted youth B. She, said, he could have come behind her, but no one ever told her youth A came through the door after her. When asked whether she recalled Mr. McClendon working the day of the incident, Ms. McConnico said Mr. McClendon had, but that he didn't work the Horizon group/youth A's group. She, said she, Mr. Solomon, Mr. Roberts, and Mr.

Shawn did so. She, denied witnessing the restraint of youth A. She, said “I just heard him being restrained.” When asked what she meant, Ms. McConnico said she heard youth A footsteps, that he was pacing and or running; and saying he didn’t do anything to get a violation. She, said, she didn’t hear Mr. Solomon or any other staff saying anything. She, said, when she pulled youth B back from peeking out his room door, she saw Mr. Solomon with youth A already in the “PRT”(Physical Restraint Technique). She, indicated, from her glance, the restraint looked proper. She, indicated, she had worked with Mr. Solomon on various occasions; and he engages with residents; and the residents like him. She had never observed Mr. Solomon to intentional hurt or disrespect a resident, or call youth A or any resident the N word, faggot or anything negative. She denied ever hearing Mr. Solomon use the words Bitch or that’s a bitch move; and indicated “if so he never said it in front of me.”

Quality Assurance/Risk Manager Taneisha Henderson, indicated to her knowledge it may have been Mr. McClendon, who opened the door that youth A went through, not Ms. McConnico. She, indicated per assessment of the incident, and review of the video footage, Mr. Solomon and Ms. Revyn were in the hallway trying to deescalated youth A. Youth A then pushed Ms. Revyn’s hand, as she tried to deescalate him; and youth A was restrained. She, indicated, the staff involved in the incident were, Mr. Solomon, Mr. Holmes, and Mr. Turner; but Mr. Turner was not involved in the restraint.

While review of the video footage by this consultant, it showed Mr. Solomon and Mr. Holmes with youth A; they came through a door; and then took him to a wall, sort of in the corner. At that point in the video, this consultant was asked to look at the staffs’ hands. Mr. Solomon’s hand was up towards youth A’s neck; and Mr. Holmes hand was up; and per Ms. Henderson, Handle with Care mandates that the staff hands should be down, as should have youth A’s. The video also showed as Mr. Solomon approached the door with youth A, youth A’s head was pushed or exerted forward. The video did not actually show youth A’s head hit the door, or an object; yet Ms. Henderson identified the edge of the door as what youth A’s hit when his head was pushed or exerted forward. When asked whether Ms. Revyn or staff Mr. Howard, both identified in the video, and, seen near the door, had seen youth A’s head pushed, Ms. Henderson indicated both reported they had not. Ms. Henderson, indicated, as a result of this incident Mr. Solomon was terminated, and Mr. Holmes was given a five day suspension being the investigation.

Youth Specialist, Kyshaun Turner, employed by the facility for just over four months, recalled the incident. He, said, he saw youth A being restrained by Mr. Solomon and Mr. Holmes; the staff had youth A arms; youth A was struggling; and he (Mr. Turner) ran over to assist, but he didn’t end of needing to assist, because Mr. Solomon and Mr. Holmes, got youth A pinned to the wall; and youth A had stopped fighting and resisting. He, indicated, as he got closer, he saw the staff didn’t have youth A in a proper restraint. He, said it “was an overaggressive restraint”, which Mr. Turner said meant it was not a proper restraint, He, said, the staff had youth A’s arms bent behind his back too far; and they were being pulled; and the staff didn’t

have youth A in the PRT. Mr. Turner, indicated, youth A was not saying anything while he was present. When asked whether there was a time that he saw youth A's head being pushed, or pushed to a door or wall, Mr. Turner did not. He, said, he heard about that happening, but he did not see it. He, acknowledged, working with Mr. Solomon in the past; and recalled Mr. Solomon being a by the book staff, whom he had never witnessed harming, attempting to harm, or verbally disrespecting a resident.

Youth Specialist, Gary Solomon, denied the allegations. He, said, youth A kicked a door open, ran down the hall and tried to push past Ms. Revyn, He, said, youth A tried to attack therapist, Ms. Revyn, in that youth A pushed Ms. Revyn; and he grabbed youth A and put him in a restraint. He, said, Mr. Holmes was involved in the restraint, because Mr. Holmes was right there; but he (Mr. Solomon) initiated the restraint by grabbing one of youth A's arms; and Mr. Holmes got the other arm. He, said "they" (administration) said he got overly aggressive as they were walking with youth A; but he/they weren't. He, said, he was moving fast to get youth A down the hallway, and that just before the BMR is a cabinet; and they bumped into it, and youth A's chest hit it. He, said, "They" said he hit youth A's head; but he wouldn't do that. He, said, he was the only one trying to work with the residents.

When asked whether he recalled how he had youth A up against the wall, in the restraint, Mr. Solomon, said he had one hand on youth A's wrist and one under youth A's elbow. When this consultant informed him the video footage showed him with his hand up near youth A's neck/head, Ms. Solomon stated he did not recall that. He, said, he did not push youth A into anything, as there was no way he could have done that, because he had both hands on youth A. He, said, "They" said it was an illegal restraint, and they terminated him; even though he had never gotten a written write up, warning or a meeting about the matter.

Clinical Director, Dawn Revyn, indicated, when she arrived on the scene, she saw Mr. Solomon, and Mr. Holmes involved in a verbal consultation with youth A; and she was told youth A had walked off the unit, and Mr. Solomon was trying to get him back to the group room. She was not sure how youth A had gotten through a locked door, to where he was at, but he was not supposed to be there; and he was not responding to Mr. Solomon and Mr. Holmes. She, said, youth A was in the corner by the door; and when the door opened he tried to leave; she put her arm up and youth A grabbed her; and Mr. Solomon blind-side swooped youth A, and restrained him. Ms. Revyn, indicated, she was not sure what Mr. Holmes did, because Ms. Howard walked out of a room, and she got him to assist; and she went to group B's group room. Thereafter, she heard youth A, "yelling", saying "you're breaking my arm"; and she came out; and told the staff to put youth A down, and take him to the BMR. He, said, Mr. Solomon was restraining youth A; and youth A's feet were off the ground. When asked where Mr. Solomon hand were; Ms. Revyn indicated he had youth A pressed against the boy's OCC window. She, said, she had Mr. Howard to go to group room B. Mr. Holmes and Mr. Solomon took youth A to the BMR; and

after she arrived there, she had them to release youth A from the blindside-swoop PTR.

When asked whether at any point in time she saw Mr. Solomon push or hit youth A's head into a wall or door, Ms. Revyn indicated "NO, I didn't see the transport." She, indicated, she watched the video later; and she saw the forward push at the door entrance way. Ms. Revyn denied ever knowing Mr. Solomon to have improperly restrained a resident, or to intentionally harm a resident. She, said she has only heard rumors of "dirty restraints" being performed, but that was in general terms, not specifically directed to Mr. Solomon.

Youth Specialist, Marcus Holmes, acknowledged involvement in the restraint of youth A, with Mr. Solomon; but denied doing anything wrong. He, said, he noticed Mr. Solomon walking up and down the hallway with youth A; youth A was upset; and Mr. Solomon was trying to deescalate youth A. He, said he stayed around in case his assistance was needed; and after about fifteen or twenty minutes, Ms. Revyn arrived. He, said, Ms. Revyn spoke with youth A; and while talking to youth A, youth A pushed her; and Mr. Solomon grabbed youth A to restrain him; and he( Mr. Holmes) assisted. He, said, he pulled youth A's arms outward, so that they could take him to the wall and Mr. Solomon could get his hooks in for the PRT. He, said, Ms. Revyn walked with them as they escorted youth A to the BMR; and as soon as they got through the door they released youth A. He, said, Mr. Howard was in the hallway, but Mr. Howard was not involved in the restraint.

When asked whether at any point in time was youth A not in a proper restraint, Mr. Holmes stated, "If so I didn't see it". When asked when they had youth A against the wall where were his ( Mr. Holmes) hands positioned on youth A's body, Mr. Holmes stated his hands were on youth A's side; and he could not recall a time his hand were anywhere near youth A head, upper body, or not positioned properly. He, said, Mr. Solomon's hands were on youth A's back, that Ms. Solomon was getting his hands in proper position. Mr. Holmes, said, youth A was combative and not cooperating. When asked again if the restraint was proper; Mr. Holmes indicated initially no, but youth A was struggling; and when Mr. Solomon gained control, the restraint was proper. When asked whether there was a time youth A's head was pushed forward, or hit a door or object at any point during the restraint or escort, Mr. Holmes stated, " No I didn't see that." When asked whether at any point in time youth A stated or yelled out loud something like you hit my head on door, or you'll breaking my arm, Mr. Holmes stated "No". He, said, youth A was screaming and using profanity against Mr. Solomon.

Youth Specialist, Lamar Howard, reported familiarity with the incident; and indicated he saw it from start to finish. He, indicated, basically youth A was distraught about something, he was kicking the door hard, and Mr. Solomon was talking with him at the boy's OCC. He, indicated, then Ms. Revyn came to see what was happening; Ms. Revyn tried to talk to youth A, "but there was no talking to him". He, said, youth A pushed Ms. Revyn out the way to get pass; and Mr. Solomon and Mr. Holmes

restrained him. Mr. Howard was not sure who initiated the restraint, but from what he saw the restraint was proper, and Mr. Holmes and Mr. Solomon transported youth A to the BMR. He, indicated, the Mr. Holmes and Mr. Solomon had their hands positioned correctly for the transport, he denied seeing youth A's head being pushed, hit, or seeing Mr. Solomon's or Mr. Holmes' hands on youth A's head or upper body.

**Reviewed:**

- Incident report dated 11/22/16, which described the incident of youth A refusing to transport; exhibiting negative behavior; attempting to push pass the clinical director; and being restrained by staff; and escorted to the BMR.
- Incident Report/ Nursing note assessment dated 11/22/16, that indicated youth A had "Limited range of motion to upper extremities bilaterally, shallow cut to right cheek and slight swelling over cheek bone.
- Video footage, which showed youth A's head being pushed or exerted forward. The footage did not show youth A's head hitting or landing on any specific object. It showed Mr. Solomon and Mr. Holmes with youth A in a restraint against a wall; these staff's hands on youth A's neck/head area; and not behind the youth's back at that time.

<b>APPLICABLE RULE</b>	
<b>R 400.4158</b>	<b>Discipline.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of corporal punishment inflicted in any manner.

<b>ANALYSIS:</b>	<ul style="list-style-type: none"> <li>Youth A, indicated, his head was pushed to the door by Mr. Solomon; Mr. Solomon denied doing such, but reported youth A's body hit a cabinet during the escort.</li> <li>None of the staff interviewed, reported observing Mr. Solomon to push youth A's head into a doorway or wall; yet youth A also reported his arms were pulled upward toward his head by Mr. Solomon, hurting them; and that at one point his feet were off the ground during escort; and the clinical director who was interviewed observed youth A's feet being lifted off the ground during the restraint; and she, and one other staff interviewed, described the staff's actions during the restraint as aggressive.</li> <li>Video footage showed youth A's head being pushed or exerted forward while Mr. Solomon escorted him; and the nursing assessment performed after the restraint revealed youth A had a shallow cut to his cheek.</li> </ul> <p>Thus, although the evidence is somewhat mixed; as to whether the act of youth A's head hitting an object was intentional by the staff; youth A's injury to his cheek resulted from the staff's behavior during the restraint.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4158</b>	<b>Discipline.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (c) Verbal abuse, ridicule, or humiliation.
<b>ANALYSIS:</b>	There is no evidence to support youth A being verbally abused or humiliated by Mr. Solomon.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.4159</b>	<b>Discipline.</b>
	(1)An institution shall establish and follow written policies and procedures regarding restraint. These policies and procedures shall be available to all residents, their families, and referring agencies.

<b>ANALYSIS:</b>	The evidence showed Mr. Solomon and Mr. Holmes did not follow Handle with Care protocol. While youth A was being restrained his feet were off the floor; and Mr. Solomon and Mr. Holmes held youth A against the wall with their hands positioned on youth A's neck and head area; both of which per the clinician director, and quality assurance/risk manager are against policy per Handle with Care teaching.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptance corrective action plan continuation of the facility's current licensing status is recommended.

**January 10, 2016**

\_\_\_\_\_  
Lonia Perry Date  
Licensing Consultant

Approved By:

**January 13, 2017**

\_\_\_\_\_  
Linda Tansil Date  
Area Manager



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
LANSING

NICK LYON  
DIRECTOR

May 19, 2017

Taneisha Henderson  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: **2017C0420022**  
**Detroit Capstone**

Dear Ms. Henderson:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

enclosure

CC: Julie Avant, CEO



**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2017C0420022
<b>Complaint Receipt Date:</b>	03/20/2017
<b>Investigation Initiation Date:</b>	03/20/2017
<b>Report Due Date:</b>	05/19/2017
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	01/24/2017
<b>Expiration Date:</b>	01/23/2019
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
Youth A alleged staff Mr. Harper spat in his face, and called him a bitch.	No
Additional Findings	No

## III. METHODOLOGY

03/20/2017	Special Investigation Intake 2017C0420022
03/20/2017	Special Investigation Initiated - Face to Face Spoke with Youth A, and a resident and staff
03/24/2017	Contact - Face to Face Spoke with Director, T. Henderson and Interviewed Youth Specialists, Donovan Harper, and Rishard Ellis
04/13/2017	Contact - Face to Face Spoke with another Horizon resident
04/18/2017	Contact - Face to Face Spoke with another Horizon resident
04/25/2017	Contact - Face to Face Spoke with Youth Specialist Kennesha McConnico
05/10/2017	Discovered Youth Specialist, Mr. Orr interviewed on 3/24/17 on two other complaints was inadvertently not interviewed about this complaint
05/11/2017	Contact- Telephone Call Made Spoke with Youth Specialist, Marcus Orr
05/11/2017	Special Investigation Full Compliance

### ALLEGATION:

Youth A alleged staff Mr. Harper spat in his face; and called him a bitch.

### INVESTIGATION:

Youth A was interviewed on-site on 3/20/17. He reported that one day in February 2017 during gym time, Mr. Harper spit in his face ten times, and said don't call me a "Bitch". When asked was happening prior to Mr. Harper doing that, youth A said he and another youth (youth L for identification in this report only) were playing in the door of the gym. Mr. Harper told him to stop. Youth A said "I didn't want to, so I called him a bitch"; and Mr. Harper restrained him against the door. Youth A said

when Mr. Harper restrained him, he (Youth A) was bent over; and Mr. Harper spat on him. Youth A said Mr. Harper told Mr. Orr to wipe up the spit so the camera wouldn't see it. He said when Mr. Harper was restraining him Mr. Harper picked him up; and he asked Mr. Harper to put him down, because he knew Mr. Harper likes to pinch kids in the side. Then Mr. Harper head-butt him. When asked how does he and Mr. Harper normally get along, youth A reported not liking Mr. Harper. He said he doesn't like Mr. Harper because Mr. Harper "cuss at the kids, and calls them "Bs", (which he indicates meant Bitches). When asked whether Mr. Harper had called him the "B" word, youth A indicated he had. He said when he called Mr. Harper a "B" Mr. Harper said "I'll show you a "B"" and Mr. Harper "called me a "B". Mr. Harper said you're a "B", you're a "B".

Youth A said Mr. Orr witnessed what happened, but no resident saw or heard what Mr. Harper did. Youth A indicated the residents were in the transport line to leave the gym. When asked whether he had seen Mr. Harper do what he reported to any other resident youth A, said no.

When asked why would Mr. Harper treat him the way he reported, youth A said he didn't know. He said when he first got to the facility the staff were liking him, but now Mr. Harper and the kids call him retarded. He said Mr. Harper and the other staff "don't treat me right". Youth A indicated feeling that they all favor youth L over him. He explained that when youth L does something like bruising or hurting himself youth L goes out to the hospital, but when he (youth A) swallowed a screw he did not get to go to the hospital. When asked whether he filed a grievance related to this allegation, youth A said he had.

Three Horizon youth specialists staff, and three Horizon residents were interviewed related to this allegation.

Youth B was interviewed on-site on 3/20/17. He was not aware of an incident with youth A and Mr. Harper in the gym. He had never observed Mr. Harper to call youth A out of his name, spit on youth A, or to hit youth A in any manner.

Youth Specialist, Jason Free was interviewed on-site on 3/20/17. Mr. Free denied ever observing Mr. Harper to verbally or physically mistreat or be aggressive with youth A. He denied youth A ever telling him Mr. Harper, or any staff called him out of his name or spat on him.

Youth Specialists, Donovan Harper, and Rishard Ellis were interviewed on-site on 3/24/17.

Mr. Harper denied the allegations. He acknowledged that youth A does not like him, but stated youth A will sit and talk with him. Mr. Harper indicated he operates "by the Book", and youth A doesn't like the he can't manipulate him. He said youth A tries to do anything to not have a good day with him. For example, youth A knows he is not to get out of the transport line to get water, but youth A will ask a new staff

if he can, and causes transport issues. Then when he checks youth A on youth's A's behavior, youth A accuses him of trying to keep him at the facility longer.

Mr. Harper admitted he restrained youth A a while back in the gym. He indicated youth A punched him in the head above his eye, because he wouldn't allow youth A to leave the gym. He said he tried to deescalate youth A, and explain he couldn't allow youth A to just leave the gym, because that would put staff out of ratio for them to leave. He said youth A began kicking and punching at the door trying to injury his (youth A's) hand; so he could go to the hospital. Mr. Harper put his hand up in front of the door's window to block youth A's punches. He said after that youth A said he was done, but as youth A turned around, youth A punched him in the forehead; he initiated the restraint; and then took youth A to the BMR (Behavioral management room).

When asked whether during that gym incident, if youth A called him out of his name, Mr. Harper said youth A does that almost daily. When asked directly if youth A called him a "Bitch", Mr. Harper stated "That's his favorite word. He says shut up Bitch". Mr. Harper denied cursing or calling youth A, or any resident a "Bitch" or out of the resident's name. When asked whether he pinched youth A, or banged youth A's head, Mr. Harper stated, "No". He said youth A "kept putting his hand to the side of my pants pinching my side". Mr. Harper denied ever spitting on youth A, but stated youth A said "I spat on him that day"; but Mr. Harper said he didn't. He told youth A he didn't; and that he would never do that.

When asked whether youth L was given special treatment over youth A, Mr. Harper stated, no and explained. He reported he is aware that some residents may feel that youth L get special attention, but youth L gets extra attention due to youth L's behavior, and it being easier to get youth L calmed down by taken youth L to the side. He indicated his', and other staff's actions with youth L is more them dealing with a special issue to keep the group running, not favoritism.

Youth Specialist, Rishard Ellis denied ever observing Mr. Harper to verbally or physically mistreat or be aggressive with youth A. Nor had he observed Mr. Harper to spit on youth A or any resident. He acknowledged observing Mr. Harper restraining youth A, but he could not recall when or where that restraint took place. Nor could he recall anything unusual about that restraint. When asked whether he knew anything about Mr. Harper pinching residents, Mr. Ellis laughed and said, no. He said Mr. Harper is a "great staff. Mr. Ellis stated Mr. Harper is "Very by the Book." He said Mr. Harper generously redirects residents; and tries to let them know how they can earn points; and residents like and respect him.

Youth C was interviewed on-site on 4/18/17. Youth C had never seen any staff to hurt or spit on youth A. He had also never seen Mr. Harper to spit on, hit, kick, bang, or hurt youth A. Nor to call youth A out of youth A's name. Youth C described Mr. Harper as a "Nice staff". When asked whether he had seen youth A to spit on staff and residents, youth said, "Yes": He said youth A "has spit on a lot of people."

When asked what does staff do when youth A spits on them(staff), youth C stated, "nothing". He said "most times, the staff just walks away. He indicated when youth A spits on a resident, that resident fights or tries to fight youth A; and the staff intervenes, and the staff gives youth A a violation.

Youth D was interviewed onsite on 4/13/17. He acknowledged familiarity with youth A, Mr. Harper, Mr. Orr and Mr. Ellis; and described them. He indicated youth A was a kind of good kid, who does bad stuff when he gets upset. He reported Mr. Harper, Mr. Orr, and Mr. Ellis were ok staff "when you're on their good side (which youth D indicated meant when kids are doing what they are supposed to do). He indicated "If you do stuff and are not on their good side (meaning kid are not following the rules), they will stick to the rule book".

Youth D denied ever observing those staff or any staff to mistreat youth A. When asked whether he had ever seen a staff to attack or spit on youth A, youth D had not. When asked how the staff conducts restrains, youth D indicated staff don't go easy, and the restrains can be rough; but youth D was not aware of any staff intentionally hurting a resident.

Youth Specialist, Kennesha McConnico was interviewed on-site on 4/25/17. She acknowledged having worked with both Mr. Harper and Mr. Orr. She indicated they were both active staff, who try to make sure kids in their group get what they need. She denied ever observing either of them to be verbally or physically inappropriate with a resident. Nor had she observed either of them to spit on a resident, call a resident out of their names, or to intentionally hurt a resident during a restraint.

Youth Specialist, Marcus Orr was interviewed by telephone on 5/11/17. He recalled an incident in February 2017 where youth A was restrained by Mr. Harper in the gym. Mr. Orr said he was in the back of the gym, with another resident, whom he thinks youth A had had an issue with. Mr. Harper and youth A were in the front of the gym by the door. He said youth A was loud, was cursing; and Mr. Orr and a female staff was trying to verbally deescalated youth A. Mr. Orr denied hearing Mr. Harper to curse at youth A at the time, or ever. He reported that while youth A was cursing Mr. Harper was telling youth A to watch his language, and telling youth A he can't talk to staff like that. Mr. Orr denied hearing Mr. Harper call youth A a bitch, or to say You're a Bitch, You're a Bitch. He said that's what youth A usually says.

Mr. Orr stated a restraint did happen that day, but he did not recall the restraint being improper from where he was. He said youth A hit Mr. Harper in the head above that left eye; and was restrained. When asked how he remembered that detail information about where Mr. Harper was hit, Mr. Orr indicated because he saw Mr. Harper later that day at their facility meeting.

When asked whether any spitting was involved during the incident. Mr. Orr did not recall youth A spitting; and he denied seeing Mr. Harper to spit on youth A. He also denied being told by Mr. Harper to wipe up any spit. Additionally, he denied seeing

or being aware of Mr. Harper, or any staff pinching youth A or any resident in the side doing a restraint. He reported this was the first time he heard of something like that.

<b>APPLICABLE RULE</b>	
<b>R 400.4158</b>	<b>Discipline.</b>
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of corporal punishment inflicted in any manner. (c) Verbal abuse, ridicule, or humiliation.
<b>ANALYSIS:</b>	There is insufficient evidence to support the allegations as reported by youth A.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Continuation of the facility's current licensing status is recommended.

May 11, 2017

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:

**May 19, 2017**

Linda Tansil  
Area Manager

Date



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
LANSING

NICK LYON  
DIRECTOR

September 30, 2017

Julie Avant  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: **2017C0420047**  
**Detroit Capstone**

Dear Ms. Avant:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- An explanation why previous corrective action plans have not obtained and maintained compliance for rules found in repeat non-compliance.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

**FOR CWL ONLY**

Please note that violations of any licensing rules are also violations of the ISEP and your contract.

Sincerely,

Lonia Perry, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-3317

enclosure

CC: Taneisha Henderson, Director



**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2017C0420047
<b>Complaint Receipt Date:</b>	07/14/2017
<b>Investigation Initiation Date:</b>	07/19/2017
<b>Report Due Date:</b>	09/12/2017
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	1ST PROVISIONAL
<b>Effective Date:</b>	07/07/2017
<b>Expiration Date:</b>	01/06/2018
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION(S)

	Violation Established?
It is alleged that another resident tried to suffocate resident 1 on 6/22/17 around 2:30PM	Yes
Additional Findings	No

## III. METHODOLOGY

07/14/2017	Special Investigation Intake 2017C0420047
07/19/2017	Special Investigation Initiated - Telephone Spoke with Complainant
07/19/2017	Contact - Telephone call made Spoke with Risk Manager Joi Meeks requested incident report
07/20/2017	Contact - Face to Face Spoke with Resident 1, resident 1, youth specialists Latonya Madison, Makaila Taylor, Roshandawa Draper and Rayneicia Pettway. Also spoke with Director Taneisha Henderson
08/01/2017	Contact - Face to Face Spoke with Director T. Henderson
08/10/2017	Contact - Telephone call made Left message for prior supervisor Mr. McGuire
08/21/2017	Contact - Telephone call made Left message for prior supervisor Mr. McGuire
08/23/17	Inspection Completed- Sub-Compliance

### ALLEGATION:

It is alleged that another resident tried to suffocate resident 1 on 6/22/17 around 2:30PM.

### INVESTIGATION:

Parent A reported "my daughter was suffocated by her roommate." Parent A repeated this statement a few times during the time she spoke with this consultant. Parent A was asked whether her daughter (Resident 1) passed out or had a problem

breathing during the incident, and parent A was not sure. Parent A reported resident 1 informed her of the incident during a telephone call. Resident 1 reported returning to her room from a group session and her roommate putting a pillow on her face. Resident 1 said her roommate "suffocated her." Resident 1 said the incident occurred on June 22, 2017 between 2:30-3:00PM. Resident 1 did not report her roommate's name, whether anyone else witnessed the incident or whether she told anyone. Resident 1 said they moved her from the room two days after the incident. Parent A did not know whether resident 1 had any marks or bruises from the incident or if resident 1 received or required any medical attention. Resident 1 did not tell parent A that information and parent A had not seen resident 1.

Parent A contacted the facility about the incident. She spoke with Ms. Joi Meeks who told her not to worry about it. Ms. Meeks indicated she would follow back up with parent A but has not.

Risk Manager Joi Meeks reported resident 2, the alleged perpetrator of the suffocation is no longer resident 1's roommate. Resident 1 reported the incident the next day after its occurrence and resident 1's room was changed. At the time of this consultant's facility site visit Ms. Meeks' interview with resident 1 was pending. Ms. Meeks denied speaking directly with parent A or advising parent A not to worry about the incident.

Resident 1(age14) reported about a month prior to the interview with this consultant she and resident 2 were in their room for reflection time and resident 2 yelled out "I want to smother my roommate." Resident 2 proceeded to take her blanket from her bed then chased resident 1 around their bedroom trying to put the blanket over resident 1's face. Another resident heard resident 2 and got Ms. Taylor and Ms. Madison. When the staff arrived, resident 2 still had the blanket but she had stopped chasing resident 1. Resident 1 indicated resident 2 never got a chance to place the blanket on her face. Ms. Taylor and Ms. Madison tried to get the blanket from resident 2 and they had resident 1 step outside the room. Resident 1 was upset, scared and crying. Ms. Pettway took resident 1 to the Behavior Management Room(BMR) to calm down.

Resident 1 reported once she calmed down the staff took her back to the room with resident 2 and they had resident 2 apologize. Resident 1 said the staff didn't change her room, she wanted them to, and she did ask for the change. She wasn't sure why she did not ask for the room change. She denied being afraid of resident 2 but she reported being fearful that evening. Resident 1 could not recall the actual date of this incident but said it happened about 2:30 PM.

The following morning resident 2 came towards resident 1 again saying she was going to smother her with the blanket. Resident 1 yelled, the staff heard her and intervened. The staff changed resident 1's room at that time. Resident 1 denied that she and resident 2 argued or that they had a negative relationship before these

incidents. Resident 1 reported she told her mom later that her roommate tried to suffocate her.

Resident 1 was asked whether she felt staff did all they could to protect her from resident 2 and she indicated they did. She stated, "They did what they were supposed to and got me out of the room."

Resident 2 admitted to the allegations against her. She said "I tried to suffocate her. I was bored and I wanted her out my room." Resident 2 stated, "I took my blanket and tried putting it over her face". Resident 2 indicated she didn't put the blanket on resident 1 because Ms. Madison stopped her, that "Ms. Madison came in the room very fast."

Resident 2 said she told resident 1 she was going to smother her and she had been telling the staff all day, "I was going to smother my roommate." Resident 2 said she didn't get a chance to smother resident 1 that evening, but the next day she tried again and the staff moved resident 1. Resident 2 was asked why not ask for a room change and she stated, "because they won't do it". Resident 2 would not say whether she was just threatening resident 1 get her way or if she was really going to hurt resident 1.

It is noteworthy to report that resident 2 has had ongoing aggressive and assaultive behaviors. She can be impulsive and she has attacked her peers on more than one occasions. This consultant is aware of this information as she has completed prior specialist investigations involving resident 2, reviewed incident reports and various staff have described resident 2's behavior in that matter.

Youth Specialists Atonya Madison, Makaila Taylor (morning staff), Roshandawa Draper and Rayneicia Pettway (afternoon staff) all acknowledged an involvement in the incident. They either heard resident 2 make the statement about smothering resident 1, witnessed resident 2 attempting to assault resident 1, or resident 1 told them resident 2 tried to smother her with a pillow or blanket. They all reported observing resident 1 to be visibly upset, scared and crying, and they intervened in some manner.

Ms. Madison recalled taking resident 1 out of her room on 6/23/17 or 6/21/17 so resident 1 could calm down due to the incident. Ms. Madison said resident 1 and resident 2 were placed in their room for reflection time and resident 2 was stating, get resident 1 "out my room before I suffocate her with this blanket". As Ms. Madison walked passed she heard resident 2 made the statement again and resident 2 made the statement once more after Ms. Madison entered the room. Resident 2 moved toward resident 1 with the blanket and Ms. Madison told resident 2 to leave resident 1 alone. Resident 2 complied by moving away. Ms. Madison thought resident 2 was saying what she did as a joke but resident 1 "didn't take it that way, she was scared". Ms. Madison took resident 1 to the hallway and spoke with her. Resident 1 was not taken to the BMR, and resident 1's room was changed

after this incident. Ms. Madison indicated resident 2 wasn't upset and "just likes to say rambunctious things".

Ms. Madison said she was alone when she entered the residents' room; Ms. Taylor never entered the room while she was there. When the afternoon staff arrived, Ms. Pettway had resident 1.

Ms. Taylor was doing rounds when she observed resident 1 in resident 1's door crying. She also heard resident 2 say, "I'm about to smother my roommate". Ms. Taylor did not recall resident 2 having an item in her hand at that time." Resident 1 "looked afraid and was crying really bad".

Ms. Taylor indicated the event occurred on the morning shift and she and Ms. Madison took resident 1 to the hallway. They kept resident 1 there until the afternoon shift arrived. Ms. Taylor informed an afternoon staff person of the situation. She could not recall who that afternoon staff person was and she was not sure how the afternoon shift handled the situation thereafter. Ms. Taylor reported that prior to this incident resident 1 had reported she did not feel comfortable with resident 2. Ms. Taylor checked in with resident 1 a few days later and resident 1 said she was fine with resident 2, she was comfortable again. Then a few days later this incident occurred. Ms. Taylor reported that she is not aware that resident 1's room was changed the day she intervened with resident 1 because the following day resident 1's bed was in the hall way. She was told resident 2 was threatening resident 1 again and her room was being changed. Ms. Taylor thought resident 1's room should have been moved previously. Ms. Taylor was going to speak with resident 1's therapist about a room change but she forgot.

Ms. Draper saw resident 1 at about 3:10PM the afternoon of the incident. She said the incident occurred between resident 1 and resident 2 on the first/morning shift, sometime in June 2017. Ms. Draper didn't know the details of the incident but she was concerned with what she observed when she saw resident 1. Resident 1 was standing at her door crying hysterically, "She was really frightened". Ms. Pettway was in the room with resident 1 and resident 1 was saying resident 2 tried to smother her and she (Resident 1) didn't want to be there. Ms. Draper left the room and returned a few minutes later and took resident 1 with her. Ms. Draper did not hear resident 2 say she was going to or wanted to smother resident 2.

Ms. Draper did not take resident 1 to the BMR. She thought another staff might have because resident 1 had complained to all the shifts that she was scared and did not want to go into the room with resident 2. Ms. Draper did not have contact with Ms. Madison or Ms. Taylor related to any situation that transpired on the morning shift.

Ms. Draper and Ms. Pettway reported resident 1's room was changed, but neither were certain the room changed occurred that day. Ms. Draper acknowledged conducting rounds to resident 2's room prior to Ms. Drapers' shift ending at 11:30PM. Ms. Pettway did not recall conducting rounds to the rooms. Neither of

them could remember if resident 1 was still in the room with resident 2 when they ended their shift that evening.

Ms. Pettway did not witness an incident between resident 1 and resident 2 and she didn't know what had occurred between them until resident 1 told her. She also observed resident 1 outside her room crying and very upset. Ms. Draper took resident 1 to the BMR to talk to her/ to calm her down. Resident 1 did not report whether resident 2 had tried to smother her before.

Ms. Madison did not complete an incident report though she thought she informed the supervisor Mr. Harden or Ms. Yancey of the situation. Ms. Draper and Ms. Pettway reported the incident report would have been completed by the morning shift because the incident occurred on that shift. Both acknowledged that if an incident occurs on one shift then occurred again on the next shift, each shift would complete an incident report.

Ms. Madison, Ms. Taylor and Ms. Draper did not recall resident 1 threatening resident 1 earlier in day or shift. All three staff reported that resident 2 behaviorally acts out often. Ms. Madison said resident 2 was just being resident 2, "trying to be a bully over someone". Ms. Taylor reported resident 2 has behavior problems. Resident 2 "just reacts at times and will her take her anger out on the person with her or the weakest link". Like resident 1, because resident 1 "is nice and does not mess with anyone". Ms. Draper reported resident 2 is very defiant and "if things don't go her way she just loses it and takes her anger out on everybody, staff and residents".

Director, Ms. Taneisha Henderson reported resident 1's room did not get changed the evening of the first incident because the supervisor, Mr. McGuire spoke with both residents. A conflict resolution was conducted and Mr. McGuire thought everything was ok. The next day during the morning shift, resident 1 spoke with Ms. Madison and then voiced concern to the supervisor Ms. Yancey. Resident 1's room was changed at that time.

Ms. Henderson reported an incident report was completed on 6/22/17 for the allegation made by resident 1 that afternoon related to resident 2. She explained that a second incident report was not completed the next morning because it was not presented as a new incident.

Efforts were made to contact the facility's prior supervisor, Mr. McGuire without success.

**The following was reviewed by this consultant:**

- Incident report dated 6/22/17 for 3:45PM and was signed by supervisor Mr. McGuire. Incident report indicated after reflection, resident 1 alleged that resident 2 had physically assaulted her by attempting to smother her with a pillow case. The incident report documented that staff immediately informed the nurse and supervisor for follow up care.
- A written statement from Ms. Draper documented basically what the incident report indicated.
- A nurse's incident report dated 6/22/17 for 8:40PM indicated no injuries noted.

<b>APPLICABLE RULE</b>	
<b>R 400.4127</b>	<b>Staff-to-resident ratio.</b>
	(3) The ratio formula for direct care workers shall correspond with the institution's purpose and the needs of the residents and shall assure the continual safety, protection, and direct care and supervision of residents.
<b>ANALYSIS</b>	<p>The evidence showed:</p> <ul style="list-style-type: none"><li>• Resident 1 reported concerns to the afternoon staff related to her roommate trying or wanting to smother her with a blanket and then repeated that concern to the morning staff. The staff intervened and attempted to address the concern on both shifts by talking to resident 1 or advising resident 2 to leave resident 1 alone.</li><li>• Resident 2 admitted she made the threat against resident 1 to get resident 1 moved out the room. Resident 2's aggressive action (given her known aggressive and impulsive behavior) clearly frightened resident 1.</li><li>• The supervisor made efforts to diffuse the situation via conflict resolution with the two residents and thought he had done so, but resident 2 threatened resident 1 again the next morning.</li><li>• Notwithstanding the conflict resolution intervention, given resident 2's known aggressive and impulsive behavior there was some uncertainty as to what her actions might be toward resident 1 when left unattended. A safety</li></ul>

<b>ANALYSIS:</b>	<p>issue still existed for resident 1 and her replacement from the room with resident 2 was warranted after the first threat by resident 2. Resident 1's safety and protection was not ensured for in this instance.</p> <p><b>Consultation</b> The agency is advised to utilize further therapeutic intervention to address these types of issues.</p> <p><b>Repeat Violation, Special Investigations, 2016C0420015, 2016C0420037 and 2017C0420011, 2017C0420013, 2017C0420027.</b></p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan continuation of the facility's current licensing status is recommended.

September 12, 2017

\_\_\_\_\_  
Lonia Perry  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:

September 19, 2017

\_\_\_\_\_  
Linda Tansil  
Area Manager

\_\_\_\_\_  
Date





RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

NICK LYON  
DIRECTOR

May 30, 2018

TANEISHA HENDERSON  
Detroit Capstone  
3500 John R St.  
Detroit, MI 48201

RE: License #: CI820297847  
Investigation #: **2018C0108043**  
**Detroit Capstone**

Dear Ms. Henderson:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

A handwritten signature in black ink that reads "Deborah Will".

Deborah Will, Licensing Consultant  
MDHHS\Division of Child Welfare Licensing  
4th Floor, Suite 4B  
51111 Woodward Avenue  
Pontiac, MI 48342  
(248) 860-4532

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF COMMUNITY AND HEALTH SYSTEMS  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	CI820297847
<b>Investigation #:</b>	2018C0108043
<b>Complaint Receipt Date:</b>	04/27/2018
<b>Investigation Initiation Date:</b>	05/22/2018
<b>Report Due Date:</b>	06/26/2018
<b>Licensee Name:</b>	Detroit Behavioral Institute
<b>Licensee Address:</b>	Suite A 1333 Brewery Prk Blvd#140 Detroit, MI 48207
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator:</b>	Julie Avant, Designee
<b>Licensee Designee:</b>	Julie Avant, Designee
<b>Name of Facility:</b>	Detroit Capstone
<b>Facility Address:</b>	3500 John R St. Detroit, MI 48201
<b>Facility Telephone #:</b>	(313) 576-5009
<b>Original Issuance Date:</b>	12/23/2008
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	01/07/2018
<b>Expiration Date:</b>	01/06/2020
<b>Capacity:</b>	74
<b>Program Type:</b>	CHILD CARING INSTITUTION, PRIVATE

## II. ALLEGATION:

	Violation Established?
Supervisor F punched a former resident several times in the face	No

**Former resident T alleged Supervisor F punched her several times in the face on 4/24/18.**

## III. METHODOLOGY

04/27/2018	Special Investigation Intake 2018C0108043
05/22/2018	Investigation assigned to this consultant today  Special Investigation Initiated – Telephone Left voice message for Administrator
05/22/2018	Contact - Telephone call made Spoke with Joi Meeks; requested 4/24 incident report; staff schedule; resident's dc date, address and ph number, and FCW's name and ph number
05/22/2018	Contact - Document Received Rec'd incident report and other requested information
05/23/2018	Contact - Telephone call made Attempted to contact former resident; phone can't receive messages
05/23/2018	Contact - Telephone call made Spoke to CMO worker Tonia O'Neil; obtained former resident's updated cell number
05/23/2018	Contact - Telephone call made Interviewed former resident T
05/29/2018	Contact - Face to Face Interviewed resident and staff
05/30/2018	Exit Conference With Risk Manager

## **ALLEGATION:**

**Former resident T alleged Supervisor F punched her several times in the face on 4/24/18.**

## **INVESTIGATION:**

\*Note: There are no video cameras in the resident bedrooms

**Former Resident T, age 16, was interviewed** by phone on 5/23/18. She is a CMO-contracted individual. The alleged incident occurred on 4/24/18 and she was discharged to her mother's home on 4/30/18.

Asked about the incident, resident T stated "Supervisor F set me up. He encouraged resident D to get hyped up. I ran into resident D's room. We were fighting. Supervisor F slammed me on the floor and punched me in the face. Supervisor F, staff P and resident D were all in on the plan. Staff P will not snitch on Supervisor F...My jaw was swollen. Nurse G gave me an ice pack."

**Resident D, age 16, was interviewed** at the facility accompanied by her one-to-one staff. On the night in question, resident D said she was in her room and on one-to-one supervision for self-harm. Staff S was assigned to monitor her. Former resident T stood in resident D's doorway. The girls argued back and forth. Staff S was standing near her chair in the doorway of resident's D's room. Former resident T jumped over the staff's chair and into resident D's room. The girls punched and kicked each other.

Staff S, staff P and supervisor F entered the room and "pulled us apart." Resident D was taken to a behavior management room (BMR) by staff J. She did not see supervisor F punch former resident T.

**Staff P was interviewed.** He has worked at the facility for 2.5 years and was last trained in Handle with Care in May 2018. Staff P remembered very little about the incident. "I separated the girls. Supervisor F "blindsided swooped" former resident T and took her to a BMR." Staff P said supervisor F did not punch resident T. He had no knowledge of any injuries sustained by any party during the fight or the restraint.

**Staff S no longer works at the facility.** Thus she was not interviewed.

**Supervisor F was interviewed.** He has worked at the facility for three years and was last trained in Handle with Care in April 2018. Supervisor F stated former resident T pushed staff S and assaulted resident D (in her room.) Supervisor F responded to a call for assistance in resident D's room. When he arrived, staff S and J were breaking up


the fight. Staff J took resident D to a BMR. "I physically managed former resident T using the 'blindside swoop.' Staff S stayed there and witnessed." Blindside swoop is an approved Handle with Care single-person hold and transport technique. An incident report dated 4/24/18 by Supervisor F indicated the following:

*"...former resident T stated that she was going to physically assault resident D. Staff re-directed several times to go in her room. Former resident T then pushed past staff and physically assaulted resident D in her room. Staff intervened and former resident T became combative toward staff attempting to assault staff. Former resident T was physically managed and taken to behavior modification room. Nurse and supervisor were notified. Nurse completed health assessment of resident."*

<b>APPLICABLE RULE</b>	
<b>R 400.4158</b>	<b>Discipline.</b>
	<b>(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of corporal punishment inflicted in any manner</b>
<b>ANALYSIS:</b>	<p>Former resident T alleged Supervisor F punched her in her face immediately following a physical altercation she had with a peer. There were witnesses to the physical altercation with a peer but no evidence that Supervisor F punched her.</p> <p>If former resident T was injured in the fight on 4/24/18, it was not indicated on the incident report. The former resident did state she saw a nurse and was given an ice pack, presumably for her sore jaw. Clearly there was a physical altercation between former resident T and resident D. However, no one witnessed supervisor F punch former resident T in her face as her allegation states. If the former resident's jaw was swollen, it was likely a result of the physical altercation with her peer.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

I recommend this facility continue its current licensing status.



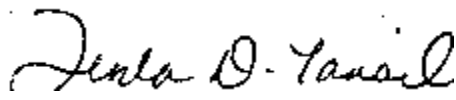
May 30, 2018

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Deborah Will  
Licensing Consultant

Date

Approved By:

 May 31, 2018

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Linda Tansil  
Area Manager

Date